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THE UNIVERSITY OF ALBERTA

ALBERTA ALCOHOLISM TREATMENT PROGRAMS
COMMUNITY DEVELOPMENT AND CITIZEN INVOLVEMENT

by

© ALEXANDER JOSEPH MacDOUGALL

A THESIS

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled Alberta Alcoholism Treatment Programs Community Development and Citizen Involvement submitted by Alexander Joseph MacDougall in partial fulfilment of the requirements for the degree of Master of Arts in Community Development.

George Kupfer
Supervisor

Date. Sept. 27/73

ABSTRACT

This thesis is an exploratory study of community development and citizen involvement in four Alberta alcoholism treatment programs. The study focuses on the extent and impact of citizen involvement within the programs of: Alcoholics Anonymous; The Henwood Rehabilitation Centre; The Edmonton Out-Patient Clinic; and the High Level community. The latter three programs are under the direction of the Alberta Alcoholism and Drug Abuse Commission. The core of the thesis is an analysis of program case studies by means of Arnstein's citizen participation scale and Dunham's citizen involvement guidelines. The findings are presented as approximations generated in the research process.

In exploring the strengths and weaknesses of each program in regard to community development and citizen involvement, the findings indicate that all four programs were concerned, in varying degrees, with the development of communities and with the self-growth of individuals within them. Elements of community development were, therefore, indicated in all programs but each was subject to limitations in terms of "community" and of "citizen involvement."

In discussing the implications for community development in each case, suggestions were made toward a more comprehensive approach to the community problem of alcoholism.

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CHAPTER I

STATEMENT OF THE PROBLEM

Introduction

Community development is mainly concerned with making maximum use of community self-initiative in the solving of its problems.

> The core of community development is an assessment and mobilization of all available resources toward as rich and balanced community life as possible. It gets its special character from an insistence on involving the citizen in the efforts. Its ultimate aim is safeguarding those human values we hold most important (Stensland, 1961, p. 81).

In the efforts of communities to promote the "good life" by means of programs to combat such problems as poverty, pollution, poor housing and poor health, community development is seen by notable authors in the field as having a great deal to contribute because it stresses that "everyone has something to contribute to the life of the community" (Dunham, 1970, p. 171).

One of the problems of increasing community, national and international concern for which solutions have not been found is the problem of alcoholism.

> The World Health Organization has estimated that in both Canada and the United States the prevalence of dependence on alcohol is 100 times greater than dependence on narcotics. This is just one indication of the seriousness which should be attached to the treatment of this our most widespread drug-dependence problem (Treatment: A Report of The Commission of Inquiry Into The Non-Medical Use of Drugs, 1972, p. 42).

A Report on the Alberta Mental Health Study of 1968, directed by Dr. W.R.N. Blair and commissioned by the Government of Alberta, recommended, in regard to treatment and prevention, that alcoholism should be considered as an aspect of mental health (Blair, 1969, p. 277). As such, it is "everybody's business" requiring "active and sustained participation by a sizeable part of Alberta's society. . ." (Blair, 1969, p. 17). Community development rests on the belief that most communities, like most individuals, have the desire and indeed the energy and resources for self-improvement. The Blair Report notes that:

> . . . many of the required resources are present in the Province and they are ready and willing to be committed. They require only a plan for an integrated operation, plus leadership and support from the Government (Blair, 1969, p. 17).

The writer's concern with alcoholism as a community and as a personal problem grew out of several years as a Roman Catholic clergyman in a number of different Alberta communities. Personal experiences in these communities and direct involvement with Alcoholics Anonymous have led to the conviction that many communities are like alcoholics in that they do not like to admit that they have a problem with alcohol. Many communities by their attitudes, beliefs, and traditions with respect to drinking contribute in large measure to conditions which not only permit alcoholism to develop, but which, in fact, tend to foster its development in susceptible individuals. The community is, in turn, affected economically, socially, spiritually and in diverse other more subtle ways by alcoholism.

As the writer proceeded with a program of studies in community development, he became increasingly aware of the potential of this approach for the changing of community attitudes. Considering the focus of community development to be "group responsibility for the local common good," (Biddle and Biddle, 1965, p. 78) it becomes very clear that communities not only have the right and the ability for self-improvement, but that individual self-improvement is their responsibility. That this responsibility extends to the problem of alcoholism has been noted by Dr. M.M. Glatt in a paper read to the Medical Council on Alcoholism in London, England in 1972:

> As it accepts, and indeed often encourages, the use of alcohol the community has a clear responsibility of preventing its abuse and assisting those who have become casualties (Glatt, 1972, p. 17).

The extent and impact of citizen involvement in alcoholism treatment programs is but one measure of the acceptance by a community of this responsibility. It is hoped that the observations and the insights gained from this investigation will have worthwhile implications both for the problem of alcoholism, as well as for community development.

Purpose of the Study

This study is designed to achieve the following objectives:

1. To describe four Alberta alcoholism treatment programs and their current approaches to the problem.
2. To examine the extent and impact of citizen involvement in these programs.
3. To indicate the strengths and weaknesses of the selected programs in terms of citizen involvement and community development.
4. To discuss the implications for community development theory and practice.

Significance of the Study

Existing alcoholism programs in 1969 have been found to be inadequate in reducing alcoholism as noted in the Blair Report. ". . .it is apparent that the current delivery systems for the treatment and rehabilitation of persons addicted to alcohol are inadequate " (Blair, 1969, p. 272). This study has significance in that it may well indicate that a program based upon the community development approach through citizen involvement has shown, or could show, a greater degree of success in terms of treatment.

When the World Health Organization (W.H.O.) came into being in 1948 the problem of alcohol and alcoholism was considered as an area of public health activity and as a valid concern of the organization (Tongue, 1970, p. 3). By 1964 an understanding of community development came to be recognized by the W.H.O. as essential for all health workers, whether in the alcoholism field or otherwise. In 1964 a report on the PAHO/WHO Inter-Regional Conference on the Postgraduate Preparation of Health Workers for Health Education spelled out the minimum program of instruction that should be made available to all health workers. This included:

> 1. An understanding of the whole process of community development and the different approaches used.
>
> 2. Knowledge of community development objectives and plans of the student's own country and of the country where the student is carrying out his programme of studies.
>
> 3. Knowledge of the health education opportunities of all workers concerned with the promotion of community development and the action required to help them make an appropriate contribution (W.H.O. Technical Report Series No. 278, 1964, p. 24).

It is apparent that the W.H.O. considered community development as having a significant role to play in public health and, therefore, in the problem of alcoholism. This study of that role in four specific provincial programs has significance in that it may contribute to a more effective approach not only to the problem of alcoholism but also to the problem of public health in general.

Plan of the Study

This study consists of three sections.

The first section is made up of two chapters providing information of a general introductory nature. Chapter I provides a brief introduction to the problem with the writer's reasons for involvement. It includes the purpose of the study with the reasons for which it was undertaken. It gives a description of the research procedures by which the purposes were achieved and concludes with a statement of the limitations of the study. Chapter II provides background information on alcoholism and clarifies some of the concepts to be used in the study.

The second section considers the alcoholism programs of: Alcoholics Anonymous, the Henwood Rehabilitation Centre, the Edmonton Out-Patient Clinic and the community of High Level. These programs will be described in terms of: a) a case study which constitutes Chapter III; and b) the role of citizen involvement, which constitutes Chapter IV. An analysis of the effectiveness of citizen involvement in terms of community development principles constitutes Chapter V.

The third section consists of one concluding chapter which considers implications and offers suggestions and recommendations.

Research Procedures

This study is a formulative or exploratory study which Selltiz, Jahoda, Deutsch, and Cook define as a study ". . .to gain familiarity with a phenomenon or to achieve new insights into it, often in order to formulate a more precise research problem or to develop hypotheses" (Selltiz et al., 1959, p. 50). As an exploratory investigation this study is essentially concerned with generating insights and hypotheses regarding Alberta alcholism programs as they relate to citizen involvement. The interpretation of the findings relied on the use of sensitizing concepts which are defined as, ". . .those kinds of terms which give a sense of reference, a general orientation, rather than a precise definition, to a phenomenon under study" (Bruyn, 1966, p. 32). Bruyn goes on to state that, "The sensitizing concept is flexible in its usage and finds a certain virtue in its inexactness" (Bruyn, 1966, p. 33). It is, therefore, not intended that the findings of this study be rigorously interpreted in terms of citizen involvement, nor in terms of the broader dimension of community development theory and practice. Rather, it is intended that this study will serve as a starting point for more intensive research into the application of community development theory and practice to the community problem of alcoholism.

The primary method of research was by participant observation in the Alcoholics Anonymous program for several years and in one of the five day teaching and training seminars of the Henwood program. The writer attended the series of six lectures and films on alcoholism as presented by the Edmonton Out-Patient Clinic. Two days were spent in High Level, Alberta, five humdred miles north of Edmonton, locating and interviewing citizens.

Loosely structured interviews and extended discussions were undertaken over a one-year period with participants and officials of the various programs.

The writer's conceptual and theoretical base was formed by reviewing related literature on alcoholism and community development.

Additional important sources of data were the informational booklets of the various programs, selected reports, research papers and newspaper articles.

Limitations of the Study

In the case of the Henwood Rehabilitation Centre and of the Edmonton Out-Patient Clinic, they are not only both under the auspices of the Alberta Alcoholism and Drug Abuse Commission but they both share the same administrative control structure. This results in the general philosophy and policy of both programs being more easily influenced by some of the same administrative staff. This is considered a limitation in that more varied, and perhaps more innovative, approaches to treatment and to citizen involvement could be expected if this were not so. While the High Level program is also under the auspices of the Alberta Alcoholism and Drug Abuse Commission, the writer does not consider that this same limitation applies in this case. The reason for this is that the High Level program is considered by the Commission as a sort of "pilot project" under the direction of a community development officer hired by the Commission to act as an "encourager" to the project.

The distance and time factor in regard to the High Level program are also limitations. This resulted in only a small number of informants being interviewed who were residents of the immediate area of High Level.

This study is also subject to observer and informant bias. It is difficult to determine if another observer would come to the same conclusions. The writer attempted to interview a cross-section of individuals in order to adequately reflect people's knowledge and perceptions about the program in question.

Every attempt was made to portray the programs as those involved described them. An attempt was made not to exclude any relevant perspective even if they were in disagreement with other views presented. The author notes his own interpretation and its' source when necessary.

CHAPTER 11

CONSIDERATION OF SIGNIFICANT TERMS

Extensive correspondence since February of 1972 between the writer and several of those involved in alcoholism treatment programs in the United States and other parts of Canada has not revealed a community development focus in these treatment programs. In a search of the available literature the writer was unable to discover information directly related to the thesis topic.

Before exploring Alberta alcoholism programs some consideration of significant terms becomes necessary. The apparent lack of a community development approach to alcoholism programming outside of Alberta and of previous relevant research lends greater importance to this chapter which will offer background information on alcoholism, community, community development and citizen involvement.

Alcoholism

Alcoholism is a compound problem and this fact in itself creates considerable difficulty for those who would deal with it. In this section the writer will consider the problem of alcoholism in terms of its definition and as a disease, in terms of its effects and of its prevalence. Finally, alcoholism will be considered as a treatment problem.

Definition

A review of the literature on alcoholism reveals a general controversy over its definition. Many theories of the etiology of alcoholism have been proposed in an attempt to identify the conditions which cause some persons to become alcoholics while others maintain control of their drinking. "The scarcity of well-established facts about the etiology of alcoholism has permitted the survival thus far of diverse conflicting theories" (Wallgren and Barry, 1970, p. 726). The lack of a standard terminology on the subject is recognized as being a problem itself (Hudolin, 1970, p. 140). The World Health Organization definition is often favorably quoted and considered in the literature since it is general in nature and includes aspects of etiology which are acceptable to many professionals in the field, while still allowing for the development of further interpretation and theory.

> Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it results in noticeable mental disturbance or an interference with their bodily and mental health, their interpersonal relations, and their smooth social and economic functioning; or who show the prodromal signs of such developments (W.H.O. Technical Report Series No, 48, 1952, p. 16).

Complimentary to the definition by the World Health Organization is that by the Alberta Alcoholism and Drug Abuse Commission. It is in this sense then, and as defined below, that alcoholism is understood in this study.

> Alcoholism can be defined as any continuing drinking behavior which impairs, with progressive seriousness, an individual's ability to function in the domestic, vocational or social areas of his or her life (A.A.D.A.C., "Recognition, Consultation and Referral of Alcoholics," Jan/71, p. 2 (pamphlet)).

The preceding paragraphs indicate that in regard to alcoholism one cannot focus solely on the medical problems. It is a disorder involving the behavior of man which relates to many different fields. All of the programs to be investigated in this study, however, officially consider alcoholism as a disease, which involves the field of medicine. A brief consideration of this disease concept will, therefore, lead to a better understanding of the approach of the programs to the problem of treatment.

Disease Concept

The concept of alcoholism as a disease is accepted by many professionals in the alcoholism field as well as by Alcoholics Anonymous. This disease concept has been important in helping to counteract the long held belief that alcoholics were morally inadequate persons who wilfully brought problems upon themselves through their own weakness or sinfulness. Viewing alcoholism in the medical health context has made it possible for the helping and healing approach to take the place of the judgmental approaches of the past. Research studies that have been undertaken within the medical health and social science settings probably would not have taken place had the former concepts of the nature of alcoholism still remained.

Critics of the "disease" concept maintain that this connotation may lead many to consider alcoholism as a disease entity caused by specific biochemical or physiological aberrations. Others, who still consider the problem from a moral aspect, object on the grounds that this provides the alcoholic with an excuse which keeps him from taking any responsibility for his condition (Clinebell, 1959, p. 335). Two highly respected researchers point out, in their comprehensive summary of scientific knowledge about the action of alcohol, that alcoholism is a complex, variable disorder which cannot readily be classified as a single coherent disease" (Wallgren and Barry, 1970, p. 773).

In 1957, the American Medical Association expressed the opinion that alcoholism represents a deviation from a state of health; and as such is a medical illness (Smith, 1959, p. 5). The North American Association of Alcoholism Programs, a United States and Canadian organization of governmental alcoholism programs, established the Co-operative Commission on the Study of Alcoholism in 1961. Members are chosen from both Canada and the United States. The comprehensive health view of alcoholism as considered by the Cooperative Commission on the Study of Alcoholism includes the disease concept and stresses the many factors which may initiate and determine the developmental course of the problem. This view also includes an awareness of the need to utilize a variety of treatment and preventive approaches, non-medical as well as medical (Plaut, 1967, p. 45). Alcoholism is, therefore, to be considered in this study as an illness which has a variety of physiological, psychological and social causes.

Some indications of the impact of this illness upon our country is illustrated in the following paragraphs.

Effects

Alcoholism is a problem that deals not only with the individual, insofar as the life expectancy of an alcoholic is considered to be ten to twelve years shorter than the average (Treatment: A Report of the Commission of Inquiry into The Non-Medical Use of Drugs, 1972, p. 42), and insofar as it has become the fourth major illness in Canada (Edmonton Journal, July 6, 1973, p. 21), but it becomes apparent that each alcoholic adversely affects economically, physically and mentally the lives of many other persons.

The effect of alcoholism on industry, the crime rate, traffic accidents, disruption of family life, and on the community generally is known to be large but very difficult to document accurately.

> Studies in the United States have shown that the average alcoholic costs his company anywhere from $1,500 to $4,000 a year. In most cases, he is only 50 per cent efficient on the job, is absent 22 days a year, requires four times as much medical attention as a non-alcoholic worker, is seven times as likely to have an automobile accident, and lives 12 years less. If he is fired, or quits, the company must spend $1,500 to $2,000 to train a replacement (Orr, 1972, p. 43).

The same writer goes on to indicate that the Canadian estimate by the Ontario Addiction Research Foundation is that the employee who is an alcoholic, "costs his company about 25 per cent of his annual salary" (Orr, 1972, p. 43).

A study in Ontario comparing the driving history of 98 persons considered as alcoholics with that of the general driving population found that alcoholics have "two and a half times as many accidents, nine times as many convictions for drunken and impaired driving and six times as many license suspensions as would be expected" (Selzer, 1969, p. 12). One writer notes that research has shown alcoholics to be involved in "approximately 50 per cent of all alcohol-related accidents" (Mann, 1971, p. 289).

It has been estimated that twenty to twenty-five percent of all those who seek help from social workers for marital disharmony consider excessive drinking as the major source of the problem (Mann, 1971, p. 291). Thus, one can safely assume that alcoholism is far more than just an individual problem.

Prevalence

While in the mass media a growing interest and concern is shown in regard to drug dependence in general, it has been estimated by the World Health Organization that the prevalence of dependence upon alcohol in both the United States and Canada is a hundred times greater than the dependence on narcotics (Treatment: A Report of the Commission of Inquiry into the Non-Medical Use of Drugs, 1972, p. 42).

For a number of reasons it is very difficult to obtain, by direct reporting, any consistent measurement of the extent or prevalence of alcoholism. First of all, the gradual onset of the disorder in any one person makes it impossible to say that yesterday he was not an alcoholic and today he is. Secondly, public attitudes have been a problem. Just as with tuberculosis or venereal disease, there has been a reluctance to report or even to admit the existence of a case of alcoholism. Also, this tendency has been exaggerated by the fact that, at least until recently, alcoholism was not widely regarded as an illness at all but rather as a moral shortcoming. Certainly it is difficult for an unskilled observer to distinguish between simple cases of occasional excessive drinking on the one hand and alcoholism viewed as a pathological and habitual addictive dependence on the use of alcohol on the other. It is quite possible that in some cultures there are many alcoholics who rarely if ever get visibly drunk.

Dr. E.M. Jellinek developed a formula which has been widely used as a means of determining the number of alcoholics in a population. This formula is based upon the discovery by Dr. Jellinek of a definite relationship between reported deaths from cirrhosis of the liver and the number of alcoholics in a given community at a given time (Glasscote et al., 1967), p. 11).

The estimates of Table 1 are based upon the above noted Jellinek formula. According to this table the increase from 12,368 alcoholics in 1960 to 21,325 in 1970 shows an increase of 72.4 per cent in the prevalence of alcoholism in Alberta during a ten year period. One can also note that deaths from cirrhosis of the liver increased in a parallel fashion.

The statistics for this table were made available to the author by the Alberta Alcohol and Drug Abuse Commission and they show the Commission's estimate of the number of alcoholics in the Province of Alberta for the years 1960 to 1970. It must be noted that the exact figure is unknown and could be somewhat higher or lower.

The Treatment Problem

One of the reasons why alcoholism is considered as a major problem is because of its impact on the behavior of the individual - both while drinking and subsequently. The very fact that alcoholism is frequently accompanied by anti-social behavior is a major factor in the emotionally charged atmosphere surrounding both professional and lay attitudes toward it. Alcoholism does not conform to the traditional disease model. It's cause is not specific. There is no well-defined area of biological pathology. Its natural history remains unclear and there is still much uncertainty about its treatment (Cahn, 1970, p. 6).

The many different public and professional views and theories about the causes and nature of alcoholism determine, in large measure, how

TABLE 1

ESTIMATES OF THE NUMBER OF ALCOHOLICS IN THE PROVINCE OF ALBERTA FOR THE YEARS 1960-1970

Year	Total Population	Population Aged 20 & Older	Deaths from cirrhosis			No. of Alcoholics	Alcoholics per 100,000 aged 20 and Older
			Male	Female	Total		
1960	1,283,000	738,400	34	24	58	12,368	1,674
1961	1,331,944	763,616	45	17	62	13,221	1,731
1962	1,370,000	780,200	32	13	45	9,596	1,229
1963	1,405,000	794,500	44	17	61	13,008	1,637
1964	1,432,000	805,000	45	26	71	15,141	1,880
1965	1,451,000	814,300	48	24	72	15,354	1,885
1966	1,463,203	823,438	37	20	57	12,155	1,476
1967	1,490,000	842,400	48	29	77	16,420	1,949
1968	1,526,000	868,100	50	33	83	17,700	2,038
1969	1,561,000	896,500	67	30	97	20,684	2,307
1970	1,600,000	926,200	64	36	100	21,325	2,302

Source: Alberta Alcoholism and Drug Abuse Commission.

persons with this particular illness are treated, how they are considered by the helping agencies, how they see themselves, and how they are regarded by the public.

> At present Canada has no organized means of reaching problem drinkers who are unwilling to seek help. The social stigma still attached to alcoholism account for considerable rationalization by alcoholics, as well as outright refusal of treatment, normally not associated with 'acceptable' diseases. Once the individual's declining physical condition or his social downfall force him to acknowledge that he is an alcoholic, the type of treatment agency that will take him in depends largely upon his socio-economic status and his projected chances for recovery (Treatment: A Report of the Commission of Inquiry into the Non-Medical Use of Drugs, 1972, p. 42).

The provision of treatment to alcoholics is complicated because each alcoholic differs from the other in so many ways. Not only is there a great variance in their drinking patterns, but also in their physical health, psychological condition, and economic circumstances. Some are in need of immediate attention for their physical problems while others primarily require psychotherapy for emotional difficulties. For still others vocational readjustment is an urgent need.

It is necessary, therefore, in any consideration of treatment, to take into account more than the drinking itself. A sound treatment policy requires that a general assessment be made of each patient's physical, emotional, social, and economic assets and liabilities, as well as of his drinking problem. The problems inherent in such a treatment policy which must take into account that the peculiar needs of each alcoholic requires a variety of treatment settings is emphasized by Dr. Ronald J. Catanzaro:

> Another facet in the total treatment approach is the necessity for the existence of a wide variety of treatment settings. The needs, abilities, desires and motivations of alcoholics

> vary tremendously. Skid-row alcoholics need such treatment settings as are offered by court and stockade programs, by halfway houses and Salvation Army lodges, by city hospitals and sheltered workshops. The middle-class alcoholic is better suited to intensive psychological therapy from his personal physician, his pastor, an alcoholism clinic or an adult psychiatric clinic. The skid-row alcoholic will often be just as out of place in the latter group of treatment facilities as the middle-class alcoholic would be in treatment facilities serving primarily indigents. The very wealthy alcoholic may only feel comfortable in a treatment setting involving 'the best doctor and medical center' in the area (Catanzaro, 1968, p. 7).

While treatment may decrease the suffering and help maintain or restore social functioning, it is generally recognized that preventive approaches must also be utilized in order that the prevalence of alcoholism and its related problems can be lessened (Cahn, 1970, p. 8).

The type of treatment approach mentioned above, while it does include a form of prevention, has not even been able to cope with the present caseload let alone arrest the development of further cases. This is strikingly pointed out by an example given in regard to the State of California. It is considered that, using the best available estimates, to provide all problem drinkers in the State with weekly psychiatric contact and monthly social worker contact would necessitate the "full time work of every psychiatrist and every trained social worker in the United States" (Plaut, 1967, p. 120). This would imply that the present type of "after the fact" or "picking up the pieces" approach to the problem is not sufficient to deal with those presently afflicted, let alone deal with preventing further development. It becomes obvious that other approaches must be seriously considered. The case for the necessity of prevention to be considered along with treatment has been well presented by Wilkinson:

> Experts on drinking problems have often talked of the need for prevention, but when it comes to detailed rigorously thought-out proposals, they have had much more to say about treatment, about attempts to cure people who already have drinking disorders. Yet treatment alone can never be a solution. In a sense, reliance on treatment by itself is an admission of failure, for it means that one only tries to help people who are already in trouble (Wilkinson, 1970, p. 4).

In the light of these observations, the author considers that a major weakness of "Treatment: A Report of the Commission of Inquiry into the Non-Medical Use of Drugs" is the omission of any specific discussion of, or recommendation for, the prevention of alcoholism in Canada. This in spite of the fact that such recommendations for prevention were made in regard to opiate dependence and chronic speed users. This omission is all the more glaring since that same "Report" notes that ". . .in both Canada and the United States the prevalence of dependence on alcohol is 100 times greater than dependence on narcotics" (Treatment: A Report of the Commission of Inquiry into the Non-Medical Use of Drugs, 1972, p. 42). Consequently it is all the more refreshing to note that in Alberta the responsibility for a much greater governmental involvement in all areas of alcoholism programs is at least publicly recognized by the Ghitter Report."

> The report called on the Alberta government in conjunction with federal authorities to increase its involvement in the alcoholism prevention field, and take the lead in encouraging other governments to develop a national organization to co-ordinate programs and research aimed at prevention, treatment and education (Edmonton Journal, July 6, 1973, p. 21).

We have seen that the definition of alcoholism is a problem, as is its various causes and effects. This illness is an extensive problem with increasing prevalence. We have seen that the solution is not to be found by way of treating each new case as it comes along. Some type of "treatment cum prevention" approach must be found which would include whole communities and the whole of society. This type of approach may well lie in

> . . .the creation of a better and more humane society - one in which individuals can realize their potential and which includes ample room for diversity. Such a society might well have fewer problem drinkers (Plaut, 1967, p. 122).

Since this study is concerned with exploring specific treatment programs in terms of a community development approach, it becomes necessary to consider the concept of community at this time.

Community

A review of some of the literature on community reveals that social scientists have not achieved a consensus on just what the term "community" denotes. The concept has proven to have a wealth of meaning. "Community" seems to be one of those great words, like "truth" or "love," whose definition is inexhaustible and significant for every man in every period of history. It has been noted that in an analysis of 94 definitions of the community there was unanimous agreement, however, that the concept was found to include social interaction, area, and common ties (Sanders, 1958, p. 120). In regard to this concept of community, Poplin states that:

> . . . it is within a community that an individual can satisfy all his physical, psychological, social and economic needs. As such, a community may encompass a territorial area as small as a household or as large as a nation (Poplin, 1972, p. 122).

In this study, "community" is to be understood as consisting of ". . . persons in social interaction within a geographic area and having one or more additional common ties" (Hillery, 1955, p. 111).

"Persons in social interaction" are to be understood as both the staff and the participants of the four programs under study and the host political communities served by the programs. Since the four programs to be considered are not all within the same locality it becomes necessary to define the community which refers to each case in terms of "geographic area."

The geographic area referred to in the case study of the programs of both Alcoholics Anonymous and the Edmonton Out-Patient Clinic is the City of Edmonton. In the case of the Henwood Rehabilitation Centre program, Edmonton is also the geographic area referred to because of the proximity of the Centre to the City, as well as because of its dependence upon, and great interaction with, Edmonton services. In addition, the greater number of program participants and/or patients have consistently been from the City of Edmonton. The geographic area referred to in regard to the High Level program is the town of High Level, Alberta including an area within a radius of approximately fifty miles of the town.

Having defined the meaning and scope of "community" in terms of this study, the writer now turns to a consideration of community development as one of the most significant terms of this study and from which a consideration of "citizen involvement" emanates.

Community Development

Like the concept of "community" much of the conceptual confusion that often arises from the use of the term "community development" may be partly due to attempts to consider it in its perfect form which is, in one writer's words, ". . .an ideal to be kept in mind, a goal to strive toward but one that can never quite be achieved" (Wileden, 1970, p. 80).

It is apparent that some writers stress the process content of community development while others contend that process must be directed toward action as the goal. Arthur Dunham remarks that "process without concrete objectives is like 'faith without works' - dead" (Dunham, 1970, p. 188). Roland Warren contends that community development is not only process but also program and that one is as important as the other.

He considers what is accomplished to be just as important as how it is accomplished (Warren, 1971, p. 87). Wileden agrees with those who consider community development as a process but disagrees with those who limit it to the more formal educational aspects of the process. He agrees with Dunham and Warren in that there can be no community development until there is community action. His definition of community development is:

> . . .the balanced development of both the human and physical resources of the place we choose to think of as the community. . . .a series of changes or progressions in the achievement of some mutually agreed upon goals and objectives (Wileden, 1970, pp. 80-81).

For the purpose of this study, community development is to be understood in the above sense and as defined below:

> . . .an educational, motivational process which adheres to the concept of community self-determination of and community responsibility for the actualization of community objectives (Garvin, 1972, p. 1).

Underlying community development are certain value judgments or basic principles. In order to establish a broader and more authentic base for a community development perspective for this study, several of these principles are reviewed.

Several different authors have compiled lists of principles as guidelines to what they consider to be effective community development practice. In regard to the classification of some of these principles, Arthur Dunham notes that in the eleven lists considered there were 142 statements of individual principles (Dunham, 1963, p. 141). From the several lists available, the writer has chosen for the purpose of this study to select six of the ten community development principles stated in a United Nations Report, not because they are considered as a final, definitive, or necessarily the best list, but for two main reasons:

1. The writer feels, on the basis of his training and experience, that they best illustrate the type of thinking that one finds in the community development field.

2. Community development seeks to bring about changes in the lives and motivation of people so that a certain set of values and beliefs have come to be associated with it. Among these values are:

> . . . an emphasis on the whole community and all aspects of community life; helping people to develop qualities of self-awareness, participation and involvement in community affairs, self-direction, and cooperation; the use of consensus where it can be achieved; self-help; basing programs on felt needs, so far as feasible; and an emphasis on the integration of specialties in the service of the community (Dunham, 1970, p. 192).

The writer feels that these basic values are of particular importance to the present study and are inherent in the principles selected. The six community development principles selected are:

> 1. Activities undertaken must correspond to the basic needs of the community; the first projects should be initiated in response to the expressed needs of the people.

2. Changed attitudes in people are as important as the material achievements of community projects during the initial stages of development.

3. Community development aims at increased and better participation of the people in community affairs.

4. The identification, encouragement and training of local leadership should be a basic objective in any program.

5. To be fully effective, communities' self-help projects require both intensive and extensive assistance from the Government.

6. The resources of voluntary non-governmental organizations should be fully utilized in community development programs at the local, national and international levels ("Social Progress Through Community Development, 1955, pp. 8-13).

Citizen Involvement

It has been stated in the section on "community" that "persons in social interaction" are to be understood as the staff and participants of the various programs, as well as the citizens of local political communities. For the purpose of this study, these "staff and participants" of programs are to be understood as "citizens."

In the introduction to this study, it was noted that community development gets its special character from an insistence on involving the citizens in the efforts to establish a balanced community life. Freeman Compton states that:

> Community development is people involvement in decision-making; it is a means of broadening the political power base - it implies meaningful, as opposed to token, citizen participation (Compton, 1971, p. 388).

This citizen involvement, or "meaningful citizen participation" dimension of community development is stressed by most authors in the field.

> Most authors agree that the concept of community development implies a broad participation by members of the community. In fact, the concept of community development may be identified with or measured by the participation base (Nelson et al., 1960, p. 251).

Since few absolutes adhere to the mode of citizen participation (Spiegel, 1968, p. 4), there is a wide range of definitions which range from access to decision-making through the ballot, through various stages of tokenism, to citizen control. This problem of definition becomes understandable when we consider the broad scope and many facets of citizen participation as on a continuum as expressed by Spiegel:

> Thresholds of participation extend from information giving, on the one end of the continuum, through consultation, negotiation, shared policy and decision-making, joint planning, delegation of planning responsibility, and finally to neighborhood control (Spiegel, 1968, p. 1).

As previously noted, citizen involvement in the community development sense implies meaningful, as opposed to token, citizen participation. In the community development sense citizen involvement is, therefore, considered as a group method of decision making. This "group method. . . involves cooperative study, group decisions, collective action, and joint evaluation that leads to continuing action" (Biddle and Biddle, 1966, p. 78).

For the purpose of this study, citizen involvement is to be understood as a group method of meaningful, as opposed to token, citizen participation in deciding policy objectives, program goals and methods, as well as their implementation.

Not only are there implications for citizen involvement in alcoholism treatment programs but for alcoholism considered in the context of mental health. Within the general context of mental health Klein believes that serious consequences for the individual and for community life results from a lack of citizen involvement in the massive changes which can take place today by decisions from the "top-down" (Klein, 1968, p. 141). In regard to these changes he goes on to say that:

> When these are brought about without involvement either of himself or of those whom he trusts, the community (in the eyes of the citizen) becomes less secure and safe, less concerned with his significance, and more fraught with uncertainties that are added to all the other problems of life. There are many instances of community conflict and disruption of needed programs to show that the alienation of the individual weakens the community. In my opinion it also renders the individual more vulnerable to the kinds of social and emotional malaise with which the mental health field is most concerned (Klein, 1968, p. 141).

Particularly in view of the fact that three of the four programs to be considered in this study are under the direct administration of a single government agency, it is of special interest from a community development perspective to examine them in the light of citizen involvement.

> The decentralization of the decision-making process through encouraging citizen participation should help government to become more responsive and to reflect more adequately local needs and aspirations (Head, 1971, p. 27).

Since the intent of this study is to examine the impact of citizen involvement on the four programs in question, the writer feels that some means of further clarification of the citizen involvement dimension of the programs would be useful. This is seen as a means of facilitating greater insight and understanding in terms of a more general community development point of view. In order, therefore, to clarify, and to some extent determine, the extent of citizen involvement in the four programs, an adaptation of Arnstein's ladder of participation (Arnstein, 1971, pp. 70-91) was utilized as a useful framework for analysis as well as an adaptation of Dunham's citizen involvement guide (Dunham, 1970, pp. 330-331).

Arnstein's eight rung typology attempts to arrange citizen participation in a ladder imagery with each rung of the ladder corresponding to the extent of influence and control that citizens exert over a plan or program. While Arnstein acknowledges that the eight-rung ladder of participation is indeed a simplification of the real world of people and programs, she presents it as an aid to illustrate a point which is of concern to this study - "that there are significant graduations of citizen participation" (Arnstein, 1971, p. 73).

Eight-Rung Typology of Citizen Participation

8. Citizen control	Degree of Citizen Power
7. Delegated power	
6. Partnership	
5. Placation	Degrees of Tokenism
4. Consultation	
3. Informing	
2. Therapy	Non-Participation
1. Manipulation	

The bottom rungs of the ladder, Manipulation and Therapy, are considered as non-participating as their real objective is not to enable people to participate in planning or conducting programs, but to enable powerholders to "educate" participants.

1. **Manipulation:** In the name of citizen participation the bottom rung of the ladder signifies the distortion of participation as when people are placed on rubber stamp advisory committees or advisory boards to "educate" them or to gain their support.

2. **Therapy:** Under the masquerade of involving citizens in planning, the experts subject the citizens to group therapy where the real objective is to "cure" them of some pathology they are assumed to have.

3. **Informing:** The emphasis is frequently placed on a one-way flow of information. Citizens participate to the extent of hearing and reading about programs through the news media, pamphlets, posters, and responses to inquiries.

4. **Consultation:** On this rung there is still no assurance that citizen concerns and ideas will be taken into account. Some of the methods used for consulting people are attitude surveys, neighbourhood meetings and public hearings.

5. **Placation:** Some degree of influence begins at this level although it is still tokenism. Some hand-picked members are placed on boards or committees who are allowed to advise or plan but the right to judge the legitimacy of the advice is retained by the power-holders.

6. **Partnership:** Planning and decision-making responsibilities are shared through joint policy boards, planning committees, etc. After the ground rules are established they are not subject to unilateral change.

7. **Delegated Power:** At this level citizens hold the balance of power which assures accountability of the program to them.

8. **Citizen Control:** At this level citizens are in full charge of

policy and managerial aspects of the programs and they can effectively resist the efforts of any outsider to change these aspects once the funds have been committed to the program.

In discussing "How to involve citizens in 'target areas' in programs concerned with social change and social welfare," Arthur Dunham, a well-known student of community development, suggests several ways of working toward citizen involvement in local programs (Dunham, 1970, pp. 330-331). In order to establish a further sense of reference, or general orientation, the following adaptation of Dunham's suggestions will be employed in this study:

1. There must be substantial representation of residents of target areas on directive boards or committees with real decision-making power.
2. Advisory bodies from the target areas must be chosen and their advice seriously considered even though they may lack authority to make binding decisions.
3. There must be neighborhood meetings and hearings where representatives of the planning body engage in dialogue with concerned citizens in the community.
4. Citizens must be informed of program developments and suggestions are to be solicited so that there is a two-way flow of information.
5. Efforts must be made to train community leaders.
6. Volunteers should be recruited from concerned communities or segments of it.
7. Non-professional aides should be utilized as neighborhood coordinators or contact persons.

8. Target areas must be adequately represented in seminars and conferences.

9. Services must be made available on a neighborhood basis.

Arnstein's ladder of participation and Dunham's suggestions for initiating citizen involvement are used in this study as sensitizing concepts to focus on the extent and significance of citizen involvement in four specific alcoholism treatment programs in Alberta. These means will be used to clarify and give a sense of reference to citizen involvement in the four programs in terms of community development. The findings are, therefore, not intended to be rigorously interpreted but are to be seen as approximations of the extent and impact of citizen involvement. It was not always possible to acquire information on each of the citizen involvement items noted by Arnstein and Dunham.

Summary

This chapter has considered alcoholism and some of its characteristics. These have included its extent and prevalence as a community problem. It was suggested that an alternate approach to present treatment methods must be considered. Before going on to investigate the implications of a community development approach to the problem, it was felt necessary to consider other concepts. Community was briefly discussed and defined in terms of this study. Community development was also briefly discussed in terms of a definition and several basic principles. Citizen involvement was discussed as being the core of community development and as the base by which the four alcoholism treatment programs would be examined. The means of measuring this citizen involvement, or participation, were taken from Arnstein's ladder of participation and Dunham's suggestions for citizen involvement.

It now becomes appropriate to describe the four programs under study.

CHAPTER III

A DESCRIPTION OF THE ALBERTA ALCOHOLISM AND DRUG ABUSE COMMISSION AND FOUR ALCOHOLISM TREATMENT PROGRAMS

In this chapter the role of the Alberta Alcoholism and Drug Abuse Commission will be described insofar as it relates to three of the four programs to be considered. Hereafter the term Commission will be used rather than the longer designation. This role will be described under the following headings:

1. Legal base and historical setting
2. Philosophical rationale
3. Organization
4. Objectives
5. Operational role in the High Level community program.

Next the Alcoholics Anonymous program will be described, followed by the treatment and training aspects of the Henwood Rehabilitation Centre program. Thereafter the Out-Patient Clinic treatment program will be described and the chapter will conclude with a description of the High Level community program. These programs will be discussed within the following categories:

1. Historical background
2. Philosophical rationale
3. Organization
4. Objectives
5. Methods of attaining objectives
6. Clientele characteristics.

Since three of the programs are directly influenced by the Commission, several of the above categories will overlap. Only those that apply differently for each case will be specifically noted.

The Role of the Commission

Legal Base and Historical Setting

The Alberta Alcoholism and Drug Abuse Commission was incorporated on July 1, 1970 by an Act of the Government of the Province of Alberta. It consists of not more than twelve members who designate one member as Chairman of the Commission.

Philosophical Rationale

The underlying philosophy that guides the Commission in all areas of its various programs is based on the knowledge:

> That alcoholism is a medically-recognized illness with physical, psychological and social components in its origin and development.
>
> That most alcoholics can be treated successfully and can return to the role of responsible members of the community which they filled before the onset of their alcoholism.
>
> That alcoholism is a public health problem of the first magnitude (A.A.D.A.C. "Henwood," n.d., p. 1 (pamphlet)).

Organization

The Commission is divided administratively into the four regions of Lethbridge, Calgary, Red Deer and Edmonton. It is presently involved in the more northern part of the province, but there has been no formal regional organization in this area to date.

Table 2 shows the various facilities and general organization of the Edmonton Regional Office of the Commission.

TABLE 2

EDMONTON REGIONAL OFFICE ORGANIZATION

REGIONAL DIRECTOR

ADMINISTRATION

EDMONTON DRUG TREATMENT CLINIC	INTOXICATION RECOVERY CENTRE	IMPAIRED DRIVER'S PROGRAM	OUT-PATIENT CLINIC	HENWOOD REHABILITATION CENTRE
Supervisor	Manager	Moderator	Dual Supervisor	Director
Medical Patient Care and Observation Pharmacy Counselling Administration	Patient Care Hospital Counselling I.R.C. Counselling Administration	Court Counselling Counselling	Medical Counselling Administration	Medical Patient Care and Observation Counselling Administration

COURT & CORRECTIONS	CORRECTIONAL INSTITUTES	DAY CARE	HALF-WAY HOUSE	COMMUNITY SERVICES
Supervisor		Supervisor	Manager	Supervisor
Counselling	Counselling	Counselling	Counselling	Industrial Education & Training Community Development

Source: Courtesy of Edmonton Regional Director

Objectives

In an interview with the Edmonton Regional Director, the objectives of the Commission were discussed as defined in the Alcoholism and Drug Abuse Act of the Province of Alberta. A summary of these objectives are considered as: co-ordinating, promotion and/or providing to the citizens of the Province of Alberta programs of prevention and rehabilitation for alcoholism and drug abuse (Jim Edwards, Edmonton Regional Director of the Commission, personal interview, June 19, 1973).

The Chairman of the Commission noted that it recognizes that the problem of alcoholism and other drug abuses are frequently manifestations of broader social problems affecting the quality of life in our society. The Commission is, therefore, not only concerned with the accomplished fact of the drug or alcohol abuser, but with all the conditions that contributed to the development of this fact, and as such will address itself, wherever practicable, to making others aware of these conditions, and to foster attitudes and public response that would minimize or eliminate these conditions (Richard Anthony, Commission Chairman, personal interview, June 19, 1973).

Operational Role in the High Level Community Program

The type of Commission involvement in the development of an organized community alcohol and drug abuse program in High Level is as a catalyst or "encourager," and as an educator.

In this capacity the Commission encourages the community to examine the relationship between drug dependence and other social issues. Organizational skills are provided so that those who are interested may be able to organize themselves to deal with the problem.

In its educational role the Commission considers the provision of educational training seminars within the community for several persons to be preferable to taking a few individuals out of the community for training elsewhere. While primarily directed to professionally trained personnel, an additional advantage of such an educational approach is the opportunity for all interested and concerned citizens to become involved in some or all of the training seminars. In this way all existing skills and resources in the community could be more fully utilized. The educational role of the Commission has been further defined as:

> A. To initiate and develop on-going information and educational programs which will enable the community to become aware of and knowledgeable about alcoholism and drug addiction.
> B. To assist with the planning and development of programs for their identified needs.
> C. Education relating to recognition referral, treatment and prevention should be available to professional workers in existing agencies, as well as providing resource personnel and consultative and support service (Garvin, 1973, p. 4).

Basically then, the operational role of the Commission in High Level is to encourage community responsibility by developing public awareness.

Alcoholics Anonymous

The material for this case study is based upon several years of personal involvement with specific Alcoholics Anonymous groups as well as upon recent literature published by the General Service Office of the organization, or Fellowship as it is commonly called. Recent interviews with several well-known Edmonton citizens of the business and religious community who are presently active in the organization will also serve as a background. Hereafter the designation "A.A." will be used when referring to this organization.

The definition of Alcoholics Anonymous found throughout the literature of the Fellowship and often cited at A.A. group meetings is as follows:

> Alcoholics Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve this common problem and help others to recover from alcoholism.
> The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions. A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish or engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety (A.A. Fact File, 1972, p. 2 (pamphlet)).

Historical Background

A.A. began as a result of a meeting at Akron, Ohio, in 1935 between William Griffith Wilson, a New York stockbroker, and Dr. Robert Hollbrook Smith, an Akron surgeon. Both these men were alcoholics and had been in contact with the Oxford Group Movement in the United States. The Twentieth Century Encyclopedia of Religious Knowledge notes in regard to the Oxford Group Movement that:

> The conversion process of this movement was assumed to include, in addition to a conviction of sinfulness on the part of the prospective convert, willingness
> (1) to 'surrender' completely to the will of God, persons in the movement (and publicly also when guided to do so), and
> (2) to make restitution for wrongs done in the past, wherever possible (Loetscher, 1955, p. 829).

With the spiritual influence of Dr. Samuel Shoemaker, an Episcopal clergyman and the leader of the Oxford Groups in the United

States at that time, and with the moral support of Dr. William D. Silkworth of Towns Hospital at New York, who emphasized that alcoholism was a disease of mind, emotions and body, Bill W. and Dr. Bob, along with a friend called "Ebby" formed the nucleus of the first A.A. group.

As the groups multiplied and the number of recovered alcoholics increased a board of trustees was formed in 1938 and was named "The Alcoholic Foundation." An office was opened in New York to look after inquiries and to distribute the A.A. book which was in the process of publication. In 1939 the Fellowship published it's basic textbook "Alcoholics Anonymous." This textbook is often referred to by A.A. members as "The A.A. Bible," and "The Big Book." Besides an explanation of alcoholism and the A.A. way to recovery by way of the "Twelve Steps," the publication includes the personal story of over thirty recovered alcoholics from all walks of life.

By 1946 conclusions in regard to the attitudes, practice and function that were felt best suited for the purpose of A.A. were codified into what became known as the "Twelve Traditions of A.A."

In 1950 the first international convention of A.A. was held at Cleveland, Ohio, and by 1951, in response to the worldwide growth of A.A., the New York head office expanded its activities to include public relations, advice to new groups, services to hospitals and prisons and cooperation with other agencies in the alcoholism field. Also in 1951 General Service Conference was created which comprises 75 delegates representing areas in the United States and Canada.

Philosophical Rationale

The philosophical basis for the A.A. way of life is found in the Twelve Steps Program which is, in turn, based upon some of the basic religious teaching of the Oxford Group, as already noted. It is not a condition of A.A. membership that there be total acceptance of these twelve steps. They are not given as commandments to be followed but as reports of action taken by ones who are seen as having recovered. The implication is, of course, that if the alcoholic wants the sobriety he sees in the group he will endeavor to progress from the first to the last step. The Twelve Step Program consists of the following:

(1) We admitted we are powerless over alcohol - that our lives had become unmanageable.

(2) Came to believe that a Power greater than ourselves could restore us to sanity.

(3) Made a decision to turn our will and our lives over to the care of God as we understood Him.

(4) Made a searching and fearless moral inventory of ourselves.

(5) Admitted to God, to ourselves, and to another human being, the exact nature of our wrongs.

(6) Were entirely ready to have God remove all these defects of character.

(7) Humbly asked Him to remove our shortcomings.

(8) Made a list of all persons we have harmed, and became willing to make amends to them all.

(9) Made direct amends to such people wherever possible, except when to do so would injure them or others.

(10) Continued to take personal inventory and when we were wrong promptly admitted it.

(11) Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

(12) Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs (A.A. Fact File, 1972, p. 9 (pamphlet)).

While the Twelve Steps Program is seen as a means to a balanced and healthy, physical, emotional and spiritual life for the individual alcoholic, there developed Twelve Traditions which were seen as the means to a healthy and cohesive A.A. "Community." These Twelve Traditions are policy statements and general principles which apply to group conduct and public relations. Although these traditions are not specifically binding on any group or groups, they have been accepted and endorsed by the Fellowship as a whole at the first international convention of A.A. at Cleveland, Ohio in 1950 (A.A. Fact File, 1972, p. 5 (pamphlet)).

The Twelve Traditions are:

(1) Our common welfare should come first; personal recovery depends upon A.A. unity.

(2) For our group purpose there is but one ultimate authority - a loving God as he may express himself in our group conscience. Our leaders are but trusted servants - they do not govern.

(3) The only requirement for A.A. membership is a desire to stop drinking.

(4) Each group should be autonomous, except in matters affecting other groups or A.A. as a whole.

(5) Each group has but one primary purpose - to carry its message to the alcoholic who still suffers.

(6) An A.A. group ought never endorse, finance or lend the A.A. name to any related facility or outside enterprise lest problems of money, property and prestige divert us from our primary spiritual aim.

(7) Every A.A. group ought to be fully self-supporting, declining outside contributions.

(8) Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.

(9) A.A., as such, ought never to be organized; but we may create service boards or committees directly responsible to those they serve.

(10) Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never to be drawn into public controversy.

(11) Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.

(12) Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles above personalities (A.A. Fact File, 1972, p. 5 (pamphlet)).

The primary purpose of A.A. is to enable the alcoholic to stop drinking but it is also concerned with the total rehabilitation and general well being of the individual. This serves to reinforce the primary purpose. In a similar way the Twelve Steps are directed toward the well being of the individual while the Twelve Traditions are directed toward the well being of A.A. as a whole. The Twelve Traditions serve as a reinforcement to the Twelve Steps.

Organization

The ninth Tradition of A.A. is, "A.A. as such, ought never to be organized; but we may create service boards or committees directly responsible to those they serve." There is, therefore, no organization in the formal or political sense and there are no governing officers.

There are two operating bodies:

(1) A.A. worldwide services, directed by A.A. World Services, Inc., are centered in the General Service Office in New York City, manned by a staff of 59 who keep in touch with local groups, with A.A. groups in hospitals and correctional facilities, with members and groups overseas and with thousands of 'outsiders' who turn to A.A. each year for

information on the recovery program. The staff also prepares, publishes and distributes Conference-approved literature.

(2) The A.A. GRAPEVINE, INC. publishes the Fellowship's monthly international journal (A.A. Fact File, 1972, p. 4 (pamphlet)).

The above two operating corporations are responsible to a board of trustees called the General Service Board of A.A., of whom seven are nonalcoholic friends of the Fellowship, and fourteen are A.A. members.

The membership figures listed in Table 3 are based on reports to the General office as of March 1972. It is noteworthy that some local groups are not registered with the General Service office and that other groups do not register number of members (A.A. Fact File, 1972, p. 4 (pamphlet)).

Objective

The single purpose, or objective of A.A., is to help alcoholics achieve sobriety and remain sober. As the definition states: "our primary purpose is to stay sober and help other alcoholics to achieve sobriety" (A.A. Fact File, 1972, p. 2 (pamphlet)).

Methods of Attaining Objectives

The local group meeting is the centre and heart of the A.A. Fellowship. For the recovered alcoholic who belongs to an A.A. group he now has a new point of orientation and he gradually learns that group's culture. The A.A. subculture constitutes for him a way of life which is more realistic, which enables him to get closer to people, which provides him with more emotional security and which facilitates more productive living.

There are both the closed meetings and the open meetings. The

TABLE 3

A.A. MEMBERSHIP AND GROUP INFORMATION

Groups in U.S.	10,342
Members in U.S.	181,419
Groups in Canada	1,815
Members in Canada	29,073
Groups Overseas	3,921
Members Overseas	71,349
Internationalists	388
Groups in Hospitals	783
Members in Hospitals	16,900
Groups in Prisons	915
Members in Prisons	30,300
Lone Members	478
Total Groups	17,776
Total Members	329,907
The estimated actual membership including non-reported members is more than	575,000

Source: A.A. Fact File, 1972, p. 3 (pamphlet).

closed meeting is limited to members of the local A.A. group, or visiting members from other groups. The purpose of the closed meeting is to give members an opportunity to discuss particular phases of their alcoholic problem which they feel is best understood by other alcoholics. Alcoholics who are particularly concerned about their anonymity usually belong to a closed group. These meetings are usually conducted with maximum informality and all members are encouraged to participate in the discussions. Each group is free to work out its own customs and ways of holding meetings, as long as it does not hurt other groups or A.A. as a whole.

The members elect a chairman, a secretary and other group officers. These officers do not give orders. Their function is to see that the meetings run smoothly. In the average group, new officers are elected twice a year. In some groups the office of chairman is rotated for each meeting. The chairman, or group leader, suggests the aspect of alcoholism to be discussed and may ask that a particular article on alcoholism be read and considered for discussion. The consensus of the group is obtained on the matter before proceeding. The chairman is expected to direct the discussion whether it follows a reading or not, so that each member has the opportunity to express himself in relation to the subject chosen. The meeting adjourns at a time agreed upon beforehand and in some cases, with the Lord's Prayer. Coffee or soft drinks with light refreshments are usually served during which informal visiting continues.

An open meeting of A.A. is a group meeting that any member of the community, alcoholic or non-alcoholic, may attend. The obligation is that of not disclosing the names of A.A. members outside of the meeting.

A typical open meeting will usually have a chairman who has been elected. The chairman usually opens the meeting with a brief description of the A.A. program for the benefit of newcomers in the audience and introduces several speakers who relate their personal experiences with alcohol, and who sometimes give their personal interpretation of A.A.

Clientele Characteristics

There are no formal A.A. membership lists so that it is not possible to obtain accurate figures on membership at any given time. It must also be considered that attendance at group meetings is not always regular in that one member may attend a different group five times a week while another may attend only once per month. The following statistics are derived from "A Multi Member Study in the U.S. and Canada" published in pamphlet form in September of 1972:

> One out of four alcoholics is a woman.
>
> The largest age group represented is from 31 to 50, which comprises 50 per cent of the membership. Ten per cent are under 31. Ten per cent are over 65 and thirty per cent are between 51 and 65.
>
> Occupationally, 39 per cent of the members are executives, professionals or technicians. Twenty per cent are tradesmen. Twenty per cent are in service industries or semi-skilled laborers and ten per cent is comprised of those from other occupations.
>
> Of the women represented in A.A. 40 per cent are homemakers, 20 per cent are in the sales or clerical field, 20 per cent are in the executive, professional or technical field, 10 per cent are in the service occupation or are semi-skilled workers. Ten per cent is comprised of those from other occupations (A.A. Member Study, 1972, p. 2 (pamphlet)).

Thus, A.A. is basically an informal self-help society comprised of an estimated 575,000 recovered alcoholics in Canada, the United States and many other countries.

The Henwood Rehabilitation Centre Program

Historical Background

Henwood is a 64 bed residential alcoholism rehabilitation centre which was established in 1968 under the auspices of the Division of Alcoholism of the Alberta Department of Health. On July 1, 1970 the Division of Alcoholism became the Alberta Alcoholism and Drug Abuse Commission by an Act of the Government of the Province of Alberta. The Centre is supported by annual grants from the Government of the Province of Alberta through the Commission. Hereafter the designation "Centre" will be used when referring to this organization.

The Centre is classified as a hospital although the treatment program is essentially non-medical in nature and is of 28 days duration. While mainly a treatment centre, it also serves as an alcoholism training centre and as a research information centre.

Those who come to Henwood for treatment do so voluntarily and are referred by a physician together with another person from a community social agency. This other person could be a counsellor, a public health nurse, a judge, a clergyman, a parole officer, an Alcoholics Anonymous member, or any other person whose public or private avocation would bring him in contact with someone suffering from alcoholism. Custodial responsibility is not assumed by the staff or administration. The Centre is described in their brochure as:

> . . . an 'institute for living.' It is designed to be an 'agent for change' in the lives of certain alcoholics who require more intensive and prolonged therapy in a 'community' setting, structured and supervised, but not authoritarian (Division of Alcoholism, "Henwood Rehabilitation Centre: Statement of Philosophy, Policy, Procedure," 1968, p. 2 (brochure)).

Organization

The administrative staff is made up of the Director and Assistant Director, a business manager and an educational supervisor. A medical doctor is employed on a one-half time basis. The Assistant Director, as the treatment supervisor, is responsible for a total treatment team of 31.

The counselling staff of 22 make up the largest group on the treatment tream. This group is supplemented by six nurses, a psychologist, a recreational therapist and an occupational therapist. There are seven clerical support staff members. The organization of the Centre is depicted in Table 4.

TABLE 4

ORGANIZATION OF THE CENTRE

		DIRECTOR		
Medical Officer	Business Manager	Assistant Director (Treatment Supervisor)		Education Supervisor
	7 clerical			2 Teachers
Occupational Therapist	Recreation Therapist	Team A 11 Counsellors	Team B 11 Counsellors	Medical 6 Nurses
			Psychologist	

Source: Courtesy of Assistant Director

General Objectives

The general objectives of the Centre are:

1. To provide rehabilitation treatment for resident patients and their families.

2. To provide teaching and training for the helping professions and individuals involved in community alcoholism programs.

3. To provide practical research information in the field of alcoholism (A.A.D.A.C. "Henwood," n.d., p. 2 (pamphlet)).

Since the third objective is served by, and makes possible, this study, the writer utilizes this "research information" to a further study of the other two objectives. To this end the Centre's program will be considered as having two objectives which sometimes intertwine. These are: Rehabilitation Treatment and Teaching and Training.

Treatment Objectives. These include:

1. Interruption of the repetitive pattern of drinking.

2. Substitution of constructive attitudes and activities for disruptive and destructive patterns of living.

3. Development of self-knowledge and inner resources to cope with problems without recourse to alcohol.

4. Improvement in inter-personal relationships.

5. Solid establishment of sobriety, not as an end in itself but as a means to an end.

6. Active participation in Alcholics Anonymous (A.A.D.A.C., "Henwood," n.d., p. 3 (pamphlet)).

Teaching and Training Objectives. These objectives, as stated by the Director of the Centre in a paper delivered at the International Congress on Addictions in Amsterdam in September of 1972, are:

1. . . .to enable the participant to learn a constructive attitude toward the alcoholic and his problem.

> 2. . . .to teach the community worker as much about alcohol, social drinking, and alcoholism as is possible during a five-day time period, and also to convince him that rehabilitation and complete recovery are possible if several basic concepts are learned, absorbed, and implemented.
>
> 3. . . .to enable the seminar participant to pursue an area of specific interest and acquire the techniques and skills required in this area. . . (Blumenthal, 1972, pp. 6-7).

The main objective, incorporating the former three, is to enable the participant, after completion of the course to:

> 4. . . .act as a community co-ordinator and assume a team leadership role when leaving Henwood (Blumenthal, 1972, p. 7).

Methods of Attaining Objectives

Since the methods of attaining the treatment objectives are different from the methods of attaining the teaching and training objectives, they will be discussed separately.

Methods of Attaining Treatment Objectives. The combined services of doctor, psychologist, nurse, and counsellor are used in attempting to help the patient recognize and understand alcoholism. The counsellor plays the most consistent role in the following treatment methods:

Physical and psychological assessment.

A regimen aimed at restoration of physical and emotional health.

Information about the development and progressive phases of alcoholism and the effects of alcohol on the human body.

Individual and group therapy including sessions for problem solving and psychodrama as well as occupational and recreational therapy.

Relaxation training.

Family counselling.

Vocational counselling.

Spiritual counselling.

Introduction of Alcoholics Anonymous and participation in demonstration meetings.

After-care and follow-up (A.A.D.A.C., "Henwood," n.d., p. 4 (pamphlet)).

Methods of Attaining Teaching and Training Objectives. This part of the program is concerned with a five-day residential training course, or seminar. These courses have been described by the Director of Henwood as "Community Development-Training Courses for Interested Citizens and Social Agency Personnel" (Blumenthal, 1972, p. 1).

The seminar begins on a Sunday evening. This allows participants to become acquainted with the physical facilities as well as with each other before the formal sessions begin. On Monday morning the group is informed of the plan for the week. The group is also informed that, aside from the seminar program, they are free to participate in all aspects of the treatment program. All are encouraged to spend as much time as possible with Centre patients in both formal and informal sessions.

One afternoon is set aside for a visit to the Out-Patient Clinic in Edmonton in order that seminar participants may realize that for many alcoholics regular counselling may be all that is needed and that seminar participants could well fill this counselling need.

Seminar participants are asked to become involved in a particular open-end psychotherapy group for four consecutive mornings. In these groups the seminar participants are treated just as the other members of the group who are patients. This complete immersion into the treatment program is intended to allow the seminar participant to experience at first hand the feelings and concerns of those having alcoholism problems and of those who deal with them. The hoped for result is a much closer feeling between the seminar participant and the patient as well as a greater appreciation of the problem of alcoholism.

There is also the regular schedule of lectures and film presentations which the participants attend along with the patients. Techniques and skills in dealing with alcoholics and their problems are demonstrated by a staff member to the seminar participants in a special group.

It is considered that this seminar will equip the participant to assume a team leadership role upon returning to his own community. It is not expected that the participant will necessarily do all of the work relating to alcoholism in the community himself, but that he will involve as many concerned citizens as possible in conducting educational programs in the recognition, assessment, motivation, treatment or referral of alcoholics at the treatment level.

The methods, therefore, of attaining the teaching and training objectives of this aspect of the Henwood program necessitates participation in the five-day seminar which includes:

1. Participation in psychotherapy group sessions
2. Social interaction with patients
3. Attendance at lectures and film presentations
4. A demonstration of the techniques and skills required to deal with the problem of alcoholism.

Clientele Characteristics

Treatment aspect. Since June of 1968, over 2,000 clients have received treatment at the Centre to date, with approximately ten per cent of these returning a second time. Data collection was begun early in 1970 by way of pre-treatment questionnaires given to clients. Based upon a random sample from a total group of 958, these questionnaires indicate that the average age of this group was 40.1 years and that they had been drinking for an average of 18.9 years. Approximately 96 per cent of clients were from Alberta. Of those from Alberta, 45.2 per cent were from Edmonton, 15.6 per cent were from Calgary, 6.6 per cent were from centres of over 10,000 population, while 32.6 per cent were from smaller centres and rural areas. Some 43.8 per cent of the group were married while 74.8 per cent had children and 56.4 per cent had an educational level of at least partial high school while 1.3 per cent of these had graduate professional training. Some 39 per cent were employed full time prior to treatment while 35 per cent were unemployed. Income ranged from 13.6 per cent earning less than $1,000.00 per year to 1.4 per cent earning more than $20,000.00. Those earning between $2,501.00 and $5,000.00 per year formed the largest group of 16.7 per cent (Shandro and Nutter, 1973, pp. 1-5).

Teaching and training aspect. From September of 1968 to September 11, 1972 there were 608 participants in the teaching and training seminars. From September 11, 1972 to July 6, 1973 there were 501 participants, making a total of 1,109 participants in this part of the program to date. Further data regarding the 501 participants from September 11, 1972 to July 5, 1973 were made available to the writer. This data is shown in Table 5.

TABLE 5

VOCATIONAL DESIGNATION OF HENWOOD REHABILITATION CENTRE SEMINAR PARTICIPANTS FROM SEPTEMBER 11, 1972 TO JULY 5, 1973

Vocation	Male	Female	Total
Nurses and other hospital workers	5	137	142
Parole, probation and correctional officers	57	9	66
Dept. of Social Development	35	18	53
Commission employees	24	22	46
Community citizens	19	25	44
Family Service Bureau, City social services, welfare officers	7	15	22
Clergy	12	8	20
Court workers	17	2	19
Counsellors: John Howard Society, student counsellors, etc.	5	13	18
Students	5	9	14
Community health and volunteers	3	8	11
Native counselling, Metis Association, Friendship Centre workers	4	6	10
Employers and personnel directors	3	-	3
Others	26	7	33
Total	221	280	501

Some 445 of the seminar participants were from the Province of Alberta while 56 were from out of the province. Of the 445 from Alberta, 208 were from Edmonton, 85 were from Calgary, while 152 were from smaller Alberta centres.

Source: Seminar Supervisor, July 5, 1973 (memo).

The Out-Patient Clinic Program

Historical Background

On September 27, 1951 the Alcoholic Foundation of Alberta was incorporated through the Association of Physicians and Surgeons under the provincial Societies Act. A Board of Directors was appointed and a program was temporarily drawn up. In June of 1953 the Out-Patient Clinic and the Administration Centre was opened. In 1965 the Foundation was taken over and administered by the Provincial Department of Health as the Division of Alcoholism.

Throughout this time, and since the incorporation of the Alcoholism and Drug Abuse Commission on July 1, 1970 as the sponsoring agency, the basic objective of the clinic has not changed, due in great part to the fact that the same person has been the continuing supervisor. Hereafter this organization will be noted as the Clinic.

Organization

The administrative staff of the Clinic is made up of a business administrator and a counselling supervisor.

The fourteen counsellors make up the largest group on the treatment team which includes two nurses and a medical doctor who is employed each morning on a fee for services basis. Eight clerical and support staff complete the complement of 26 full-time staff members. The organization of the Clinic is depicted in Table 6.

Objectives

Since the Clinic is centred upon a medical treatment model with counselling services, the objectives are treatment oriented, and are

TABLE 6

ORGANIZATION OF THE CLINIC

BUSINESS ADMINISTRATOR			COUNSELLING SUPERVISOR	
Medical doctor	7 Clerical	Receptionist	14 Counsellors	2 Nurses

Source: Courtesy of Counselling Staff.

considered as:

(1) Interruption of the repetitive pattern of drinking and acceptance of the need for sobriety.

(2) Substitution of constructive attitudes and activities for disruptive and destructive patterns of living.

(3) Development of self knowledge and inner resources to cope with problems without recourse to alcohol.

(4) Improvement in interpersonal relationships.

(5) Recognition of the importance of active participation in the fellowship of A.A. (A.A.D.A.C., "Out-Patient Clinic," n.d., p. 1 (pamphlet)).

Methods of Attaining Objectives

The initial personal or telephone contact by a client establishes whether he is seeking information about alcohol and/or drugs, or whether he is seeking treatment. He is then directed to a counsellor or, in some cases, to a medical staff member.

Counselling is on a one-to-one basis in each case but is supplemented by participation in one or several groups. The client is encouraged to attend the general information group, which is a series of six basic lectures and films on alcoholism and drug abuse. These groups are open to the public and are recommended for clients and their families. From this first information group, clients are channelled into one or several of the following: initial, or advanced, wives group; relaxation training groups; discussion groups; couples groups; family counselling groups. Having participated in one or several of these groups the client may then progress to one or more of the more advanced groups. These are: patient therapy groups; couples therapy groups; communications groups.

Table 7 shows the operational aspect of the treatment methods just described.

The methods of attaining the treatment objectives of the Clinic, aside from direct medical attention, can be seen as consisting of:

1. Individual counselling
2. Joint counselling
3. Information giving
4. Group participation.

Clientele Characteristics

The client population of the clinic is composed of individuals from every socio-economic level of the community. While a complete social history and assessment is made upon the client's initial involvement with the clinic, there has been no attempt to compile these personal statistics other than to classify them as patients, relatives, or non-relatives, or to classify them according to sex.

The average monthly caseload in 1973 consisted of 400 clients and is as high as 550 in some months.

TABLE 7

OPERATIONAL ASPECT OF THE CLINIC

			Counselling a) Indiv. b) Joint		Initial Wives Groups	Advanced Wives Groups	
	Phone Contact		Information		Relaxation training group		Patient therapy groups
Patients Family		Kardex		Information Groups	Discussion groups		Couples therapy groups
	Reception				Couples groups		Communication groups
			Medical doctor nurses Counselling		Family counselling groups		

Source: Courtesy of Counselling Staff.

The caseload summary for the month of April 1973 shows that 144 males and 47 female patients were forwarded from the previous month along with 110 relatives of patients, making a total of 301. To be forwarded to the month of May were 170 male and 54 female patients along with 138 relatives of patients, for a total of 362.

The basic purpose of this clinic is to provide out-patient alcoholism treatment. Situated in the downtown Edmonton area, it also serves as an information service as well as a referral agency to other facilities for alcoholics.

The High Level Community Program

The material for this section was obtained from personal interviews with Mr. William Wacko, the former Director of the Alberta Alcoholism and Drug Abuse Commission, as well as from numerous discussions with Mr. Terry Garvin, formerly of the Commission field staff. Several administrative memos were made available as well as personal files and reports of Mr. Garvin on the High Level Community Program.

While the writer is not primarily concerned with the problem of drug abuse, as frequently mentioned in the following case study, its inclusion is considered necessary in reflecting the authentic role of the Commission. This inclusion is not considered as having a detrimental effect upon the study as a description of an alcoholism program.

Historical Background

During the latter part of 1971 it was becoming increasingly apparent to the Commission that there was a growing willingness on the part of communities to become more involved in the solution to the problem of alcohol and drug abuse. A demonstration of this trend was the degree of effort and the extent of participation by the community of Vermilion, Alberta in arranging a Drug Seminar in May of 1971 in that town. There were approximately 200 participants in this seminar from Vermilion and the surrounding area at which Mr. Archer Tongue, the Executive Director of the International Council on Alcohol and Addictions, was the guest speaker.

From this time the Commission began to give greater consideration to the need for more citizen involvement, especially in communities where there was no treatment facilities.

A Community Development Regional Program was envisioned as one which would involve and assist professional people and the community leaders in coping with local problems arising from harmful use of alcohol and drugs. Further to this, a new role of the Commission as a catalyst was seen as bringing about changes in the attitudes of individuals in a particular community, or region of communities. This, hopefully, would result in citizens generally becoming more concerned with early intervention in the pathology of dependencies.

In order to assist the Commission staff to gain a greater understanding of the dynamics of community involvement and to aid in the formulation of a community development approach to the problems of alcohol and drug abuse, a community development person was employed by the Commission in May of 1972.

During several group meetings with the staff of the Commission over a three to five-month period, the techniques and principles of community development were explained and discussed. The necessity of establishing a philosophical basis for the new role of the Commission was recognized during these meetings, as well as the need for a workable community development model.

Philosophical Rationale

The following basic philosophical principles apply to the Commission's community development approach in the High Level community and to the proposed expansion of services to other communities in Northern Alberta. These originated from the Commission staff discussions of 1972.

> 1. Any Commission involvement will attempt to adhere to the principles of community development as a process.
>
> 2. Any action or program proposed must be based upon the necessity of responding to community needs in a way meaningful to the community.
>
> 3. Any involvement by the Commission in a community should not be a substitute for resources which are already present in the community. This is to ensure that other local resources will not opt out of any responsibility which they could assume themselves.
>
> 4. In responding to the need of a particular community the Commission is to be recognized by the community as a credible and authoritative voice of the Government of Alberta. This will maintain consistency in the methods and quality of treatment and prevention as well as ensure government support for community programs (Garvin, 1972, pp. 2-3).

These philosophical principles form the basis of a community development model. The model is intended as a conceptual framework within which extended service to several different types of northern communities besides High Level may be considered. This model is defined as:

> . . .an educational, motivational process which adheres to the concept of community self-determination of and community responsibility for the actualization of community objectives (Garvin, 1972, p. 1).

Organization

The Commission considered that a specific and rigid organizational model in regard to community involvement in an alcohol and drug abuse program is not consistent with the community development process, nor with the various types of communities which come under the Commission jurisdiction. The Commission's interpretation of "Organization" as it applies to this particular program is, therefore, in agreement with Wileden's conception of organization in the broad sense as: ". . .the mutual agreement of individuals in any social situation to work together in terms of desired objectives" (Wileden, 1970, p. 171). The Commission considered that this community development model would allow for a particular community to develop an organizational structure in terms of their own "desired objectives."

Model Objectives

The objectives of this model as a community development approach to the alcohol and drug abuse problem of High Level and other communities are:

1. To provide information about alcohol and drug abuse to the community which will enable it to make decisions in regard to the problem.
2. To assist the community in identifying available resources for the solution of the problem, whether within or outside of the community.
3. To assist the community in solving their own problems in regard to alcohol and drug abuse and thus enhance the community's decision-making process.
4. To encourage the establishment of a type of community organization

or structure which will assume the responsibility for matters related to alcohol and drugs.

5. To develop public awareness.

It is anticipated that the realization of these objectives will enable High Level and other communities to become totally aware of all aspects of alcohol and drug use, with citizens effectively making the decisions which will result in an improved quality of community life.

Methods of Attaining Objectives

The following methods used by the Commission to reach the above objectives in High Level result in a further clarification of the "operational role" of the Commission in the program as noted in Chapter III.

These methods include:

1. The setting up of workshops to train the participants in the organizational skills necessary to establish a community structure which would assume the responsibility for solving their own alcoholism and drug abuse probl[illegible]

2. The setting up of educational seminars directed toward providing information about alcohol and drug abuse to the participants.

3. The assignment of resource personnel to the community.

4. The provision of the necessary financial assistance for continuing educational training projects and program staff members.

The Commission considered that the practice of the above methods will result in an increasing public awareness of the problems of alcoholism and drug abuse.

Clientele Characteristics

In recognition of the community development process which is being attempted by the Commission in High Level, it is necessary to consider some of the characteristics of the "clientele" or citizens who are, or who are hopefully to become, involved in this process.

High Level as a "New Town" (and thus administered by the Provincial Government) is less than ten years old and owes its development mainly to expanded oil exploration as well as to the opening up of large tracts of homestead farmland in the general area. Its present population of about 2,000 is made up of professional, business, skilled and semi-skilled personnel who, with their families, are permanent residents. At any one time there is a substantial number of transient oilfield workers, road building and construction crews who reside in the town.

Within a radius of approximately fifty miles there are several smaller predominantly Indian communities, Indian Reservations and Metis Colonies. Their residents regularly commute to High Level for professional, business and social purposes. It is estimated that the professional and business community of the town serves a population of about 8,000.

In brief then, the High Level community program was designed by Commission staff to encourage community participation, to analyze and define community problems, as well as to promote co-operation in seeking solutions.

CHAPTER IV

CITIZEN INVOLVEMENT IN THE FOUR PROGRAMS

Introduction

In this chapter the role of citizen involvement in the programs of Alcoholics Anonymous, The Henwood Rehabilitation Centre, The Edmonton Out-Patient Clinic and High Level community will be discussed.

In the case of A.A. the role of citizen involvement will first be discussed as it applies to the group meetings, which meetings are considered by members as being the "centre and heart of the A.A. fellowship." Following this will be a discussion of the public relations policy of A.A. as it relates to citizen involvement.

The rehabilitation treatment and the teaching and training objectives of the Centre program will be considered separately. In discussing rehabilitation treatment, the role of citizen involvement will be considered in terms of: 1) staff involvement; and 2) patient involvement. The role of citizen involvement in teaching and training will be considered along with the methods of attaining them.

In the Clinic the role of citizen involvement will be discussed, as in the case of Henwood, in terms of: 1) staff involvement; and 2) patient involvement.

The role of citizen involvement in the High Level program will be discussed within the context of the methods used to attain the program objectives and within the context of the interviews held.

It is to be understood that it is not the purpose of this study to consider the role of citizen involvement in the Provincial Civil

Servants Union, of which the staff of the Centre, the Clinic and the Commission are members.

Alcoholics Anonymous

A.A. is a fellowship with an emphasis upon mutual help. The professional person, the businessman, the beautiful and the ugly, the rich and the poor are all considered as equal in status although not equal in social class. This equality, besides satisfying the need to belong, ensures acceptance of the person at fair value as an alcoholic. This equality also means that no member, or members, have the authority to expel another. There are no professional staff members such as psychiatrists and medical doctors who are directly associated with it in a professional way. There is, in fact, no staff at all. This results in no status divisions between clients and staff such as are found in other types of alcoholism treatment programs.

As stated in Chapter III, the primary objective of A.A. is "to stay sober and to help other alcoholics to achieve sobriety." The two parts of this one objective are, therefore: 1) to stay sober; and 2) to help other alcoholics to achieve sobriety. While it is acknowledged that these two are not mutually exclusive, the writer will consider them separately insofar as the means of remaining sober involves group meetings and the means of "carrying the message" involves public relations.

Group meetings

A.A. membership precludes attendance at group meetings where the discussions centre around the individual application of the Twelve Steps and Twelve Traditions as a means of remaining sober. The fourth Tradition states: "Each group should be autonomous, except in matters affecting other groups or A.A. as a whole." Each group is considered as an individual entity having the right to be wrong, but enabled to make decisions concerning its internal affairs. Because of the guidelines of the "Twelve Steps" and other traditions, the scope for these group decisions is limited. This is so because the basic philosophy, the program methods and general policy have already been decided upon and are dictated by the steps and traditions. Involved would be such small matters as: the particular "steps" to be emphasized at one or more meetings; the location of meetings and whether they are to be "open" or "closed" meetings; the choice of a guest speaker; the time and length of meetings; the size of group; etc.

Frequently the term "group conscience" is heard in A.A. meetings. There is no power structure in the strict sense. Everyone has an equal right to be heard and is encouraged to present his view which is then freely discussed. All decisions made are by majority vote although unanimous agreement is common. The members of each group meeting are in full charge of all managerial aspects of the program.

A significant aspect of the group meetings is that when the expressed norms and values of various members conflict an effort is made, and most often succeeds, to achieve some unanimity as to the goals and purposes of life. A consensus is most often reached as to the relationship of alcoholism to the generally accepted value system.

Public Relations

In order to achieve the second part of the A.A. objective, which is to help other alcoholics to achieve sobriety, members are expected and encouraged to practise the twelfth Step, which states: "Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practise these principles in all our affairs." The "message," as a part of the A.A. program, may be carried in different ways, both individually and as a group.

The individual reassurance and support lent to other alcoholics by the presence of another at a meeting is considered twelfth Step work. Also involved is responding individually to requests for help in crisis situations from other suffering alcoholics.

The emphasis upon mutual help characterized by twelfth step work is indicated by each new member's introduction to A.A. by way of a sponsor. This sponsor is a person who has himself been successfully coping with an alcohol problem and who feels that he is now ready at all times to help the new member. Sometimes the group as a whole suggest which members should respond to which new members. This may have to do with social class or occupation, time or distance. Very often the sponsor will be an old friend or past drinking companion of the new member. The sponsor may ask the new member's wife or employer for support and understanding in the situation. Eventually the sponsor will take the new member to A.A. meetings. The relationship of sponsor to new member, and of one member to another results in a sense of solidarity and group identification.

This method of sponsorship allows the sponsor to see himself as he was before in the image of the recently drunken new member. The new member sees himself as he would like to be. Each is, therefore, a reinforcement to the other. The attitudes and motives of the new member about the use of alcohol are replaced with new ones.

By his association with other members, the new member is not under social pressure to drink. He is under the social pressure of the group not to drink even though respect for the rights of others is stressed - to the point of respecting a member's "right" to get drunk if he wishes. This social pressure is typified by mottoes such as: "but for the Grace of God, there go I" and the "24 hour plan." This 24 hour plan, or program, is a phrase used to describe the A.A. approach to staying sober. The member does not commit himself to not taking a drink "tomorrow." Very often in the past the alcoholic has found that the compulsion to drink has proven to be more powerful than his best intentions not to drink. The current 24 hours is the only period that he feels that he can do anything about as far as drinking is concerned. The following "Sanskrit Proverb" expresses very well the philosophy of this "twenty four hour plan" and it is used in A.A. literature.

> Look to this day,
> For it is life,
> The very life of life.
> In its brief course lies all
> The realities and verities of existence,
> The bliss of growth,
> The splendor of action,
> The glory of power -
>
> For yesterday is but a dream
> And tomorrow is only a vision.
> But today, well lived,
> Makes every yesterday a dream
>   of happiness
> And every tomorrow a vision of hope.

> Look well, therefore, to this day.
> (Hazelden, n.d., p. 3).

The A.A. public relations policy in a less restricted sense is guided by the eleventh Tradition, which states: "Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films." In some areas, members have established public relations or public information committees to assist local media in obtaining accurate information about the Society. The decisions as to how such informational and educational ends are met are made at the level of the group meeting. All the members of one group, for example, may decide to help out with a particular educational effort. In this sense the group would be helping the general public to become informed about alcohol, alcoholism and A.A. They would also be helping other alcoholics to begin on the road to achieving sobriety.

A.A. can, therefore, be seen to be comprised of groups of citizens who are involved in the making and implementation of meaningful decisions. It is seen primarily as a method of group support for individual decisions. The group decision-making power in regard to basic philosophy, program and policy, is limited only by the twelve steps and the twelve traditions.

The Henwood Rehabilitation Centre

For the purpose of this chapter the rehabilitation treatment and the teaching and training objectives of the Henwood program will be treated separately.

The Rehabilitation Treatment Objective

1. Staff involvement.

In order to gain a perspective about the role of staff involvement in the program, a brief description of the "team approach" is presented.

This team approach involves random assignment of the twenty two counsellors to two teams. This selection is usually made by the secretary on the basis of vacancies or of work load. The six nurses are also utilized to a great extent as counsellors and are included in team selection. A full team compliment is, therefore, made up of eleven counsellors and three nurses for a team total of fourteen. The services of the psychologist, the occupational therapist and the recreational therapist are supplementary to both teams. The team leader is selected by the treatment director on the basis of a competition which is set up to determine qualification and suitability for the increased responsibility of this position.

Patients are initially assigned by the secretary to a specific team on the basis of the order in which they are admitted so as to allow for a balanced case load for each team. Within each team are from two to five groups comprised from two to four counsellors and with the assignment of from four to eight patients in each group. The number and size of groups are determined by the total number of patients, the particular type of patient and the availability of counsellors at any one time.

The twice weekly meetings of each counselling team serves not only as a means of fostering communication and co-operation between counsellors but as an opportunity to share insight and discuss particular cases. At these meetings counsellors are assigned specific groups by the team leader. There is a rotation of counsellors between the groups within each team every two weeks.

During these meetings the counsellors as a team discuss whatever modification they consider necessary to the treatment program. Such a modification might be the utilization of the closed rather than the open method of group therapy for the patients. Through the sharing of counselling experience at these meetings, it may be considered that certain patients are more receptive to a certain type of therapeutic approach. The counsellors, with their team leader, then decide upon the assignment of certain patients to particular groups using a specific approach. In the area of program scheduling it may appear to the counsellor that the patients generally are more receptive to group therapy or to relaxation therapy, for example, at a time different from the time scheduled. This concern would then be brought by the team leader to the general staff meeting for discussion and decision. Should the same concern be expressed by the other team leader for his counsellors and should the program director and general director then agree on the need for change, then the schedule is modified accordingly.

In these team meetings each counsellor also has the opportunity to express his views on any matter of policy or procedure which he feels may influence the general objectives of treatment. Any one of these policy or procedural matters may range all the way from the referral and admitting policy, though the week-end pass system, use of the facilities for A.A. or alcoholism related gatherings to the breaking of house rules and discharge systems. The concerns and suggestions in regard to treatment methods, program modification or general policies and procedures which are expressed at these team meetings are brought by the team leader to the general staff meetings for consideration and approval. These staff meetings which are held twice weekly are attended by the director, the program director, the nurses and the two team leaders. One of the basic aims of the team meeting is to foster a sense of shared responsibility by providing each counsellor the opportunity to become involved in the decisions which influence the direction of the treatment program.

2. Patient involvement.

Patient involvement in the treatment program begins with their referral by a doctor, a clinic, a government agency or other source. All applications are reviewed by the director, sometimes in consultation with the medical doctor. If there is considered to be sufficient motivation, or hope for such, and if there are no medical reasons to prohibit acceptance, then a date for admission is set on a "first come first served" basis.

Upon arrival at the Centre each patient is assigned by the secretary on a random basis to a particular counsellor-patient group and then given an "Admission Folder" which contains the lecture and general program schedule. Since each patient is considered to have freely applied for treatment, he is expected to take part in the whole program as dictated by the schedule. The patient, therefore, has no choice but to attend all of the lectures, film showings, group therapy, relaxation training and counselling sessions. While each patient is assigned to a specific counsellor as well as to a particular counsellor-patient group within a team, he is free to contact any member of the counselling team for help and counselling. Full and complete co-operation from all patients is not always achieved, nor is it initially expected - hence the need for counsellors. However, should a patient continue to refuse without reasonable excuse to participate in the program, or a significant part of it, he is discharged if he has not chosen to leave of his own accord. A patient is free to leave the program at any time. Discharge follows the failure to abide by the house rules such as smoking in bed and using alcohol and/or non-prescribed drugs. A patient is also discharged if he leaves the premises within authorization or fails to return from a pass without permission.

While patients are expected to take part in the whole program as scheduled, specific problems and concerns of patients which may be related to the program may be taken up with the Patient Advisory Council. This Council, made up entirely of patients, meets each Wednesday. There is an elected chairman, secretary-treasurer, sports representative, social convener and a welcoming committee. Staff members may attend these meetings but only upon the invitation of the patient body.

Some patient concerns which are related to program modification might be a general dissatisfaction with a particular group therapy approach or a personality conflict between a group and a particular counsellor and/or his approach. It may be considered that personality conflicts between patients necessitates a reshuffling of groups, or a change of roommates. The other main areasof the Council's jurisdiction not directly related to programs are the assignment on a rotating basis of kitchen, laundry and library duties, hosting A.A. meetings and arranging for reunion weekends when applicable.

The concerns of the patients in regard to program are brought by their chairman to the administrative staff for discussion and consideration. Decisions on general house duties are usually finalized within the Council meeting.

The Teaching and Training Objective

In April 1972 the writer attended the five-day "Community Development Training Course for Interested Citizens and Social Agency Personnel." In investigating the role of citizen participation in this part of the Centre's program a consideration of the methods used to reach the objectives of this course, as stated in Chapter III, is undertaken.

The first objective is: To enable the participants of the seminar, or training course, to gain a constructive attitude toward the alcoholic and his problem.

The realization of this objective is attempted by assigning each seminar participant to a specific patient group which meets four times during the seminar for an open-ended psychotherapy group session with a staff member as therapist. During these sessions each one is encouraged to freely discuss their own feelings and problems and to respond to those of the others in the group. The emphasis during these sessions is not upon group self-determination, nor group decision-making, but upon a personal catharsis for the patient which will hopefully and eventually lead from a greater insight to the personal decision to abstain from alcohol.

While attendance at, and participation in, these group sessions may indeed be the method of most benefit to the most people in order for them "to gain a constructive attitude toward the alcoholic and his problems," there is no alternative but for the seminar participant to attend, even though he may already have, or feel that he has, this "constructive attitude." There is no discussion of whether there is a general need for a "constructive attitude," or even a desire for a change of attitude. The need for attitudinal change is assumed.

Further to the attainment of this first objective, social interaction with patients is encouraged by way of private discussion during mealtimes, coffee breaks, and free time periods. These discussions were most valuable to the writer in terms of a greater understanding of alcoholism and in terms of how an alcoholic sees himself at this Centre.

The second objective is: To teach the community worker as much about alcohol, social drinking, and alcoholism as is possible during a five-day period.

This teaching role involves the seminar participants, along with the patients, attending the regularly scheduled presentation of selected films and prepared talks in a classroom-like setting by staff members. The staff encourage the audience to react by discussing the particular subject matter of the film, or talk, after its presentation.

There is no prior consultation or joint decision-making with the participants as to the content or method of presentation. There is, therefore, no participation which would allow for other more meaningful and useful films to be viewed and/or information to be acquired at these times by those who may already have seen the particular film or who may already have acquired the information given in the particular talk. Moreover, the resulting discussions are structured around the central theme of the presentation which does not allow for other related areas of interest to be discussed and which may be of great concern to one or more present.

The third objective is: To enable the participant to pursue an area of specific interest and acquire the techniques and skills required in this area.

These interests would include:

1. Gaining a greater understanding of the problem by the spouse, relative or friend of an alcoholic in order to react in a more positive way in the future and to encourage professional treatment or counselling.

2. Additional counselling skills in order to enable Social Agency Personnel to better cope with alcoholic clients and associated problems.

As the means to this third objective, all of the seminar participants form one group with a staff member. Each participant is asked to share any personal experience with particular alcoholic cases and to join in a general discussion as to methods of dealing with the problem. Although the views of each participant are listened to and generally discussed, these views are measured against the "Proper" technique or skills.

The fourth and main objective is: To enable the participant, after completion of the course, to act as a community co-ordinator and assume a team leadership role upon his return to his own community.

The means to this main objective are assumed to have been achieved by the attainment of the others. It is, therefore, assumed by the Centre staff that those who have attended this seminar have gained a constructive attitude toward the alcoholic and his problems, an increased knowledge of alcohol and alcoholism and the techniques and skills required to deal with the problem. It follows that the citizen involvement dimension in regard to the attainment of this objective is included in the consideration of the first three.

While there is no specific leadership training component built into the seminar program it is hoped and considered by the Centre staff that a greater number of participants will take on a co-ordinating and leadership role in regard to the alcoholism problem upon returning to their own community. This expectation is heightened by the fact that consistently over eighty per cent of seminar participants are employees of social or helping agencies which lends to them a certain commitment to leadership.

In regard to the treatment objectives of the Centre, the "team approach" provides a means of group decision-making for the administrative and counselling staff. There is no such formal means of group decision-making provided for the patients in regard to treatment and program as their decisions are considered to be more of an individual than a group matter.

The objectives of the teaching and training seminar provide for more informed and trained citizens. It is intended as a resource for those who may later be in alcoholism programs, or for those who are presently involved with alcoholics. The emphasis within the seminar itself is, therefore, upon information giving rather than on group decision-making.

The Edmonton Out-Patient Clinic

Those who are being considered as citizens in this discussion of the role of citizen involvement in the Clinic are those directly concerned either as staff or as clients of the treatment program. The role of citizen involvement will, therefore, be discussed in terms of 1) staff involvement; and 2) client involvement.

1. Staff Involvement.

The counselling supervisor, who is one of the two administrative staff members, is responsible for the general co-ordination of the total treatment program. This requires the supervisor to have a good knowledge of individual and group therapy methods, as well as of personnel management. While this supervisory role includes the assignment of specific counsellors to particular groups, there is prior consultation with the counsellor concerned. Should a counsellor feel more competent in working with a general discussion group than with a family counselling group, for example, this will be taken into account with consideration for the total counselling needs of the program. On the other hand, a counsellor may have been employed because of particular specialized training or communications skills so that he would be expected to specialize in that area.

There is no single "treatment package" which the counsellor is required to follow. He has the alternative of choosing whatever type of individual treatment therapy he feels may be of most benefit at the time and in the circumstances. He may choose a particular therapeutic approach because he feels more competent in that area. This also applies to interviewing techniques used by different counsellors. Following individual counselling, it is the counsellor's responsibility to direct the client to the particular group which the counsellor feels would be of most benefit to the client. Following such assignment of a client to a particular group, it becomes the prerogative of the counsellor of that group, after consultation with and the approval of the counselling supervisor, to choose or modify a specific therapeutic approach.

Since the policies and procedures of the clinic are now formulated and somewhat static, it was not possible for the writer to obtain sufficient information to discuss in a relevant manner the role of the counselling staff in their formulation. The main reason for this is that there has been a continual turnover in staff since the incorporation of the Clinic in 1951. Conversations with the present treatment supervisor indicate that there has been a great deal of counsellor involvement in the past in regard to the policies and procedures which are now in effect. There is little or no counsellor input in this area at this time. Conversations with counselling staff members indicate that they do not feel qualified to question the general policy which has been arrived at by the joint involvement of administrative and counselling staff in the past.

2. Client Involvement.

The main responsibility of the patient who comes to this clinic is to accept the decisions which are made for him in regard to treatment. It is considered by the staff that a client has come seeking help because he has failed so often before in the making of decisions. The staff feel that is better to keep the responsibility of the client at a minimum to begin with. The patient's suggestions as to his suitability, or liking, for a particular group or method of treatment is taken into account when decisions are made for him in this regard. However, these client suggestions are weighed against the counsellor's expectations for him.

The patient has a role to play in the setting of appointment times and he may discontinue treatment at any time. All treatment is considered voluntary except that which is prescribed by the courts, i.e., the impaired driving course. The patients do not have a role to play in the formulation, or modification of policies and procedures.

Clients other than patients are family or close friends of the patients who may take part in joint counselling or group therapy sessions, as in the case of a patient's spouse. Any other citizen may take part in the general information group but will not be accepted as a participant in any other part of the program unless he or she has a drug related problem.

While the staff of the clinic are involved in individual decisions which affect clients, there is no evidence of a group method of decision-making in regard to the general program or policy. Clients are considered as more in need of being motivated to make individual decisions than they are in need of participating in group decisions.

High Level Community Program

A community development person was employed by the Alcoholism and Drug Abuse Commission in May of 1972, as noted in the previous chapter. In June of the same year a request for financial assistance was indirectly received by the Commission from a recovered alcoholic from the town of

High Level, Alberta, for the setting up of a type of Alcoholism Detoxification and Rehabilitation Centre. The letter indicated that there was a particular need in that community for such a facility because of the extent of the alcoholism problem. This man claimed that a number of other recovered alcoholics and himself had an option to buy one half section of farm land with some old buildings within four miles of the town. Their proposed plan was to set up this centre for those suffering from alcoholism, not only for High Level residents but for alcoholics from any other area. The proposed detoxification method was that of hydrotherapy, which consists of a series of systematic and carefully regulated hot baths which are successfully used in some European countries for this purpose. The proposed rehabilitation treatment was briefly described in the letter as consisting of fresh air and physical labor in the fields and gardens, combined with the raising of livestock, which was to result in the serenity of sobriety. This venture was eventually expected to become self-sufficient as well as a haven for alcoholics from far and wide.

In response to this letter a member of the Commission's staff travelled to the town several days later for further enquiry and discussion and to gain a greater understanding of the situation. On the day of his arrival a meeting was arranged with several members of the A.A. group of the town. These sober citizens were recognized as responsible and respected community members who could be counted upon for initiating further response from other citizens. Consequently, this meeting ended with the group decision to encourage as many as possible who were personally or professionally interested in the problem of alcoholism and drug abuse, to come to a second meeting arranged for the following evening. At this second meeting there were representatives from A.A., the R.C.M.P., the Department of Health and Social Development, and the general business community, as well as the local magistrate, doctor, public health nurse, hospital administrator and local Indian chief.

This group at the larger meeting was encouraged to discuss and determine in their community:

1. How the problem of alcohol and drug abuse should be dealt with.

2. How many had a personal and/or professional interest in the problem.

3. Who would be interested and willing to commit themselves to an analysis of addiction and associated problems.

4. How many would be willing to take further action if alcohol and drug abuse should be found to be considered by the community at large as a serious problem.

The result of this second meeting was that those attending decided to hold further discussions among themselves and with other community members in regard to the concerns mentioned. More importantly, the decision was made to arrange for a general workshop for all who were concerned from High Level and the surrounding area. They decided that the workshop would be an attempt by the citizens themselves specifically to:

1. Identify their area of personal concern in regard to alcohol and drugs.

2. Identify those concerns relative to their particular group and

to the larger community surrounding the town.

3. Foster community responsibility in seeking solutions.

Almost six months later a two-day workshop was held with an attendance of 45 people of whom nineteen were Indian or Metis. In attendance was a fair socio-economic cross section of the residents, not only from the town of High Level, but from six surrounding smaller communities as far as 45 miles from the town.

As resource persons only, three staff members from the Commission attended the workshop. After the larger group was divided into smaller discussion groups, the following general format was considered workable and acceptable by those in attendance.

1. Each person would give a description of a community problem.
2. Each person would choose a particular aspect of the problem they wished to deal with.
3. Each person wrote down the reasons for and the reasons against doing something about the problem which they identified.

The particular analysis and concerns of each person were discussed in the smaller groups and a co-ordinated presentation was then made and generally discussed after the groups joined together.

In this workshop the issues which most often arose were:

1. The need for alcohol and drug education.
2. Social issues: discrimination, unemployment, welfare.
3. The need for treatment and rehabilitation.
4. The need for organization coordination at the larger community level.

5. The need for preventive measures such as increased recreational facilities.

There was general agreement at this workshop that alcohol and drug programming should be placed in the health context and that the High Level Composite Health Board should have the socially defined right to initiate and foster further action. A partnership was envisioned between the Commission, the Native Counselling Services and the Alberta Hospital Commission. This workshop then closed after arrangements were made for representatives from the participating communities to meet again within one month.

During the six months following the above mentioned October workshop, several meetings were held at High Level. A five-member committee was elected in April, 1973 to formalize a proposal for a specific program to be presented to the community meeting on May 28, 1973. With some minor changes this proposal was approved at this meeting and then presented to the Composite Health Board at High Level. It was then formally presented to the Alberta Alcoholism and Drug Abuse Commission by the Composite Health Board in July, 1973.

The essence of this proposal for program development was that, with the aid of government funds, an alcoholism treatment facility be established in the town of High Level. This facility was to serve not only the town but the surrounding area. A building was made available by the town although some renovations were required. It was proposed that all the minimal permanent staff would be recovered alcoholics, while the aid of volunteer workers would be used as support staff. The initial treatment was to consist mainly of hydrotherapy followed by counselling, while the services of the local doctor would be available for emergency treatment.

It was with this background that the writer went to High Level to find and to interview some of those who had already shown a personal or professional interest in the local alcoholism problem. In consideration of the time and distance involved it was decided to concentrate on the town itself. A total of twelve hours were spent in locating several persons who had attended the previous meetings and in discussing the problem with them. A number of significant persons who had shown concern and leadership were not available. Among them were the local doctor who was on vacation, an R.C.M.P. officer who had been recently transferred, as had one social worker. Several others had moved away or were out of town on business or vacation. In spite of this, some interesting viewpoints were expressed by the individuals and groups contacted.

The R.C.M.P. constable interviewed had not attended any of the community meetings in regard to the alcoholism problem. He did feel that alcoholism in the general area was indeed serious, as indicated by the approximately 350 detentions for inebriation in 1972. The greater number of these were apparently native people from the surrounding area who came to town to "Whoop it up" when their government cheques came in. He felt that the main reason for the problem was the general lack of proper recreational facilities both within High Level and the smaller neighboring settlements. This constable suggested that there was a greater community cohesiveness in the general area of High Level than in some other towns because of the relative lack of communication from "the outside." There is no television reception in the town and very poor sporadic radio reception. He indicated that the Peace River newspaper was not read that much and that the Edmonton Journal arrived two days late to be of much interest to many. The constable considered this lack of outside communication as contributing to a good native-white relationship, as well as to an excellent R.C.M.P.-native relationship. He felt that this lack of communication hindered the Indians of the area from a greater awareness of "civil rights movements down South."

It was my distinct impression during this interview that this particular constable considered the alcoholism problem of the general area to be mainly a native problem. Some solution should be found but without giving the native people a part in the decision-making process as this might establish an unwelcome precedent.

The local hotel and tavern was suggested by one resident as perhaps the most prosperous business in the town. In an interview with the owner of this business he suggested that, although he had attended several of the community meetings in regard to the alcoholism problem, he did not feel that he had much to contribute by way of a solution. He was apparently more interested in the establishment of a "friendship centre" where native people who come to town from a long distance could be given a bed for the night rather than have them "hand around" the hotel which was giving his business a "bad name." This man implied that the native people from the surrounding area were the cause of the alcoholism problem. He stated that one would have a very difficult, if not impossible, task in finding a native male in his late teens or early twenties who had not been picked up by the R.C.M.P. at least once for intoxication. He was very reluctant to admit that alcoholism was a greater problem for the residents of the town of High Level than for any other town of comparable size.

It was my impression that the hotel owner was very concerned because of the negative implications about his own establishment in regard to the problem. He did not seem to be prepared to become involved in a community decision for a solution any more than his business prompted him to, in order to "save face" in the community.

The chief of a local Indian Band lives about one mile out of High Level town in a modern, well kept home with his wife. He had attended several community meetings as well as the workshop in the Fall of 1972. While the chief does not drink himself, he expressed very great concern for the alcoholism problem among his people. Only five native families reside in the High Level area but the chief stated that they come to High Level from as far as eighty miles away.

The chief spoke of the former Indian way of life which was to hunt and to fish to supply enough food for the day. This gave to him, he said, the sense of responsibility and respect that every man must have. It was the custom to move with the game and the seasons and to live without tension from one day to the next. As the chief himself said, "The Indian does not worry about tomorrow until tomorrow becomes today."

He claimed that the clash between the white and Indian culture is the main reason for the increasing alcoholism problem. He maintains that the government allowance has taken away the initiative of the people to work so that they have forgotten the old ways of hunting and fishing and have lost their sense of responsibility and self-respect. Now, the chief said, the first thing the Indian does when he gets his allowance is to buy a few groceries for today while he drinks all the rest, not worrying about tomorrow.

Alcoholism was not a problem to the Indians of the area, according to the chief, until the hotel beer parlour opened about two years ago. Now it has become a very serious problem, not only to the Indians but to a "great many white men" in the town and general area of High Level.

When asked about his opinion of the plan to establish an alcoholism rehabilitation centre on a farm near the town, the chief implied that the plan was more for the purpose of making money than for helping people.

In regard to the most recent proposal for an alcoholism treatment centre in the town of High Level, the chief's response was: "All the white man wants is the Indian's signature so that they can have the centre under their control and make money from it." The chief complained that if the white man is so concerned about the Indians themselves doing something about their problem then why was the committee which made up the proposal comprised of only white people? In consideration of this he was resentful of the fact that, "the white man now wants our signature."

When questioned as to what he thought he and his people may have gained from the community meetings and the workshop, the chief replied: "Everybody now knows that the Indians are not the only ones with the problem." He went on to say that his people have had many discussions among themselves as a result of the general meetings. My impression was that the extent of the concern expressed by the general area resident representatives at those community meetings led, in part, to the seven Indian Bands in the area forming an All-Band Council to deal with alcoholism among other problems. The chief claimed that it is not the Indians who have the problem in communicating with each other, but the white man. He said that the All-Band Council is against the High Level treatment centre because it would not serve the Indians so well as their own proposal which they apparently discussed in depth during the week previous to the writer's visit. This proposal was that there should be three treatment centres upon Indian Reserves. If the community is so concerned about the Indian drinking problem, said the chief, then they would obtain the funds and also go out to the reserves to deal directly with ones with the problem. He feels, along with the All-Band Council, as he said, that to have the Indian problem drinker come to the white man's town for treatment further contributes to the syndrome of always having the Indian come to the white man who has not contributed anything positive to the Indian before. Now, said the chief, is the time for the white man to show that he is really sincere by going out to where the Indians with the problem are. He felt that for the Indian with a drinking problem to come to High Level for treatment would be expecting too much since he would begin to drink again out of loneliness, being separated from his family.

Although the Indians were considered by some interviewees as being unaware of what goes on "down South" it was interesting to hear the chief speak of the federal funding for an alcoholism program on the Hobema Reserve south of Edmonton. The chief noted that in the two years since the Hobema program had been established, a great improvement is evident in the alcoholism problem there. He wondered why it took so long for the Indians of his area to be aided in the same way financially.

During this interview the interviewer was impressed with the earnestness, the insight and the awareness so freely expressed by this man, particularly since someone previously had said that "he may not say very much." His impression of the "farm plan" agrees with a comment attributed to the letter writer to the effect that he wanted a monument erected to himself in High Level before he died. While the chief did not excuse his own people for their abuse of alcohol, nor directly blame the white man, one could not ascertain whether his participation in the community meetings helped him to clarify part of the reason for the problem as cultural clash. It appeared to the writer that a general resentment toward, and distrust of, the white community contributed to the lack of open consideration by the Indians of the High Level proposal, as well as to the formulation of the counter proposal of the All-Band Council. From this interview it appeared that one very positive outcome of the community meetings, as expressed by the chief, was a collective agreement that the main social problem in both the white and Indian segments of the community was that of alcoholism. Another positive outcome appeared to have been the formation of the All-Band Council.

The writer was invited by the local hospital administrator to a meeting of some of the hospital staff, the public health nurse, and the director of the local office of the Department of Health and Social Development with his assistant. Since four of those present had attended the community workshop and most of the community meetings, this seemed to be a good opportunity to obtain a more general viewpoint of, or insight into, the extent and type of community involvement in the area.

An attempt was made to try to determine to what extent the concerns of the Indians, as expressed by the chief, were being considered by the rest of the community. The initial reaction to this was some resentment that the chief should have made known these concerns to a stranger while apparently not telling the white residents. The general feeling was that the Indians themselves must at least take the responsibility of making those concerns known. The writer was informed that although the Indians of the surrounding area participated in the workshop, they did not continue to attend the community meetings. In regard to the chief's complaint of no Indian representation on the committee elected to draw up the new proposal, the response was that they had been asked in person, by letter, and by telephone to elect a representative to the committee from every sector, or Band, of the Indian population of the surrounding area. The local Director of Health and Social Development suggested that the main reason for this lack of co-operation and non-attendance by the Indians at further meetings was the result of a certain Indian from Edmonton. He had spoken to the local Indians and convinced them that if they held back their co-operation at this point they would most likely be able to obtain their own alcoholism program similar to one on the Indian Reserve at Hobema. This outside intervention was resented by those present and it was understood that unless the community had the support of the Indians of the area, this proposal would not be accepted by the Government of the Province of Alberta through the Commission.

The writer was concerned with gaining a better understanding of the reason why the new proposal seemed to require the sanction of the Composite Health Board before submission to the Commission for approval. This concern was based on the fact that since High Level has the status of a "new town" the members of the Composite Health Board were appointed by the Minister of Health and therefore not democratically chosen by the community. The writer was informed that it had been decided at a meeting of a representative number of concerned citizens of the community. that to have the new proposal approved and presented by the Composite Health Board would "carry more weight."

It was made clear that should their new proposal for an alcoholism treatment centre become a reality within the community, the residents themselves wanted as much control as possible over the decisions to be made in regard to program and general administration. They felt that since it would be by their efforts that such a centre became a reality, it should also be by their own efforts that such a community facility be carried on. They indicated that their present Community Health Centre allows for much community involvement in the carrying out of its services.

Two reasons were given for the extent of the alcoholism problem among the white population of the area: 1) a lack of commitment of many persons to the area as they intended to stay for a short while anyway. It was felt that this attitude led to a lack of personal responsibility as well; and 2) a lack of proper recreational facilities.

There was general agreement that the proposer of the "farm plan," although sometimes a most difficult man to understand and with questionable motives, was the instigator of the subsequent community involvement by the presentation of his original plan involving the leasing of a farm.

This two-hour meeting did not prove to be as productive as had been expected. One reason for this was a seeming reluctance on the part of the others present to offer an opinion independent to that of the hospital administrator who played the dominant role in supplying information. Another reason may have been some misunderstanding by those present of the writer's role at the meeting. This possible misunderstanding may have led some of those present to feel that they could jeopardize government acceptance of the new proposal, which had already been presented, by further negative comments.

It began to become apparent that this community was less cohesive than appeared on the surface, particularly in regard to the white-Indian exchange. The hope was expressed that a further meeting arranged for August 15-16 and which was to be attended by representatives of the community, the Commission, Native Counselling Services, the Department of Northern and Indian Affairs and the All-Band Indian Council in order to further consider the new proposal already presented, would bring about better co-operation and communication. In this regard, the writer was previously assured by the chief that the Indians would certainly be present and would remain "until everything is settled once and for all."

Some initial surprise was generally indicated at this meeting that the specific efforts of this community in identifying and solving their own alcoholism problem should be of concern to the writer. Those present felt that their approach was nothing out of the ordinary and was the only "natural and proper" means for a community to consider such problems. It was specifically stated that the process was one which evolved by way of general consensus rather than by the urging of Commission staff. This attitude seemed to be particularly significant in terms of community development as a process and as encouraged by the Commission.

The next interview was with an ex-alcoholic who has established what was reported as a profitable cement business in two years of sobriety. This man told the writer that he and about twenty others in the town of High Level make up the local A.A. group. He indicated that the A.A. members, acting as private citizens and out of concern for both Indians and whites who have an alcoholism problem, are the motivating force behind the involvement of the rest of the community. He also indicated that the problem of alcoholism in the High Level area is greater than in any other northern community that he knows of and that many more are concerned and affected besides those who have voiced their concern to date. He noted that the members of A.A. in that community feel that they are able to do more to help with a solution to the problem by not being concerned with their anonymity in such a small community. "Everybody knows we did stupid things when we drank so why should we be embarrassed about everybody knowing we can do better when we're sober?" he said. He suggested that the "farm plan" initiator was one of the strongest forces behind A.A. in the community, as well as in the search for a solution to the problem.

While this man seemed to be very open and sincere, there was some suggestion of a power struggle between some A.A. members and other sectors of the community. This man was one of the supporters of the original "farm plan" proposal.

Finally, there was the interview with the controversial, aggressive and somewhat bitter "farm plan" initiator who was very hospitable.

It was with some difficulty that the writer was able occasionally to interrupt the story of this man's past history and future plans to focus on the purpose of the visit. He expressed some resentment over the non-acceptance of his private rehabilitation centre and blamed it on "that American with the beard who sits in the big chair at the hospital." Presumably this meant the hospital administrator. He claimed that the hospital administrator and some of his "henchmen" wanted the new proposal accepted so that the new centre would be under their control. In spite of this, he agreed to go along with the proposed new centre as long as his theory on the treatment benefits of hydrotherapy was accepted. He was one of those elected at a meeting called to form a committee to make up the new proposal. It becomes evident from a perusal of this proposal that he had "sold" a number of others on hydrotherapy as treatment. In answer to the writer's question, he stated that he was not willing to consider any other method of treatment.

Insofar as there are no Indians on the five man committee, he stated this again was the fault of the hospital administrator for not informing them. The writer's impression was that the interviewee did not consider this as much of a deficiency until it was mentioned at this time.

This man felt that all that was needed now was government funds to establish and support the centre as proposed. The "farm plan" initiator was not convinced that the involvement of people in developing the whole treatment approach would assist in more adequate prevention.

Judging from the interviews held, the citizens of High Level have been involved in discussing their problems during a series of community meetings. There were some decisions made as to solutions for these problems. One result was the presentation of a proposal to the Commission which, if accepted, would result in the implementation of the group decision.

CHAPTER V

THE PERCEIVED IMPACT OF CITIZEN INVOLVEMENT IN THE FOUR TREATMENT PROGRAMS

Introduction

Chapter IV presented a descriptive account of the role of citizen involvement in A.A., the Henwood Rehabilitation Centre, the Edmonton Out-Patient Clinic and the High Level community program. The present chapter will investigate the effect, or impact, of the role of citizen involvement in each of these programs as perceived by: 1) the citizens themselves; and 2) the writer.

For the purpose of this chapter it will be necessary to investigate whether there is perceived to be, in each case, a group method of meaningful, as opposed to token, citizen participation in deciding policy objectives, program goals and methods, as well as their implementation.

In order to facilitate this investigation, as indicated in Chapter II, an adaptation of Arnstein's ladder of participation and of Dunham's list of suggestions for citizen involvement were utilized. While a brief itemized summary of both these guides is presented here, it is to be noted that the items of Dunham's guide are not to be considered as on a scale, or ladder, as are those of Arnstein's typology. See pages 28-30 for the fuller treatment of the items.

Arnstein's Guide

Item 1	Manipulation
Item 2	Therapy
Item 3	Informing

Item 4 Consultation

Item 5 Placation

Item 6 Partnership

Item 7 Delegated power

Item 8 Citizen control.

Dunham's Guide

Item 1 Target area representation

Item 2 Target area advisory bodies

Item 3 Meetings: dialogue between target area and planning body

Item 4 Suggestions solicited: two-way flow of information

Item 5 Efforts to train community leaders

Item 6 Recruitment of volunteers

Item 7 Utilization of non-professional aides

Item 8 Target area representation in seminars and conferences

Item 9 Service on neighborhood basis.

Alcoholics Anonymous

A.A. members' views

Many A.A. members feel that the initial decision to attend A.A. meetings is arrived at by a combination of the force of circumstances which have made their lives intolerable, along with the conviction, sometimes reinforced by a recovered alcoholic, that something must be done about the situation. At this stage the alcoholic is not always prepared to accept the A.A. program and is not always convinced of his own need for help. He is not interested in having any influence or control over the program, but is more concerned with what effect the program will have on what he feels is his "freedon." He may feel that he is being manipulated and being subjected to a type of therapy which he is not yet ready to accept. This type of new member is considered as not yet participating in the A.A. program even though he may remain sober. As time goes on and the member begins to feel more understood and accepted for what he is, he then becomes more accepting of the program. When he realizes that his opinion is sought and respected by the other members, he begins to feel that he does have an influence upon the application of the program to others as well as to himself. With increasing confidence the new citizen-member accepts more responsibility for himself and for others to the point of his being considered by himself and by others as being an equal partner in all of the decisions which are made by the group.

Since there is no official power structure in A.A., in the sense of a power group versus a non-power group, it is not difficult for all member-citizens to share in all decisions made and to share in the responsibilities of the group.

It is the view of A.A. members that an established A.A. group represents a collection of decisions of the members to attempt to grow in the acceptance of the program goals and policy objectives of a new and positive way of life as represented by the twelve steps and twelve traditions. Since it is not a condition of membership that there be total acceptance of these steps and traditions, each member is free to interpret them according to his own ability and understanding. While each member is encouraged to participate in all of the lesser decisions internal to each group, and to share in their implementation, it is understood that there is to be no group involvement in deciding or changing program goals or policy objectives as stated in the twelve steps and twelve traditions.

The above noted decision-making limitations are not considered by A.A. members to be limitations of their participation in the A.A. program and in its application. They feel that one of the main reasons that A.A. has proven to be so successful is because its unchanging structure offers stability and direction to ones who have lost their direction. It is the position of most A.A. members that direct involvement in deciding such matters as which steps or traditions should be discussed at a particular meeting, or how many meetings are necessary for them, has much more relevance and meaning for them than to be concerned with changing the general program and policy which has already proven its efficacy, in their opinion.

While some A.A. members acknowledge that anonymity does not lend itself to public awareness, they feel that the public relations policy of A.A. in Edmonton should be expanded. They have pointed out that, while the eleventh tradition states that the A.A. public relations policy is based on attraction rather than promotion, this tradition, like all of the others, is not specifically binding upon a group, or groups. Aside from the crisis response typified by twelfth step work, it is felt by some members that there is room for much greater participation by the members in public relations work.

While it is considered by A.A. as a whole that the greatest advertisement for A.A. is the recovered alcoholic, there are local members who feel that A.A. has not yet developed an acceptable level of responsibility toward the people of Edmonton in terms of educational programs.

There are those members who maintain that A.A. must be more concerned with the here and now alcoholic who is a potential A.A. member, than with theoretical formulations. There are others who maintain that A.A. should not only respond to crisis situations and requests for information, but also should take the lead in developing greater public awareness of the dangers of alcoholism.

The writer's views

The writer's present discussion of his perception of citizen involvement in A.A. in terms of Arnstein's ladder of citizen participation is within the context of A.A. group meetings. The basic weakness of this typology as a term of reference for the group meetings is that while Arnstein's typology implies a power struggle between citizens and power-holders, or public officials, an A.A. group has no official power structure.

While there is no power structure at all in the A.A. group, the General Service Board exercises a sort of quasi-power in the name of the total membership. This power is not considered by A.A. as being in the formal or political sense.

The fourth tradition stating that "each group should be autonomous, except in matters affecting other groups or A.A. as a whole" has been accepted and endorsed by the Fellowship as a whole. The endorsement results in the General Service Board having to ensure that no group which calls itself A.A. becomes involved in changing philosophy, policy or program, as represented by the twelve steps and twelve traditions. It is for this reason then that citizen involvement in the A.A. group meeting must stop short of deciding upon basic philosophy and policy objectives as they relate to the already approved and apparently proven twelve steps and twelve traditions.

The writer will now consider citizen participation in the A.A. group meeting utilizing Arnstein's guide as the term of reference. It will be noted that not all the members of an A.A. group are necessarily at the same level of participation at one specific time.

Item 1.

Many of those who first begin to attend A.A. are manipulated, and sometimes coerced, by other members or by circumstances, to give the A.A. program a "try." While this is not necessarily a negative aspect insofar as a recovering alcoholic is concerned, it is not citizen participation in the writer's opinion, nor in terms of the guide. Therefore, most new members to A.A. are in the category of "manipulation" or "non participation."

Item 2.

Since part of the objective of A.A. is to help other alcoholics to achieve sobriety, one of the means used is to subject them to a form of group therapy which is directed to "curing" then of alcohol dependency. Most new members are initially hesitant to take an active part in this exchange so that they would fall in the "therapy" and once again the "non participation" category in terms of the guide.

Item 3.

During the first few meetings there often is not much contribution from the new member although he may be attentive and respond to inquiries. While this stage in the alcoholic's progress may be compared to Arnstein's "informing" level, where she notes that participation is limited to a one-way flow of information amounting to "tokenism" the writer does not agree. In this case, since the new member is encouraged to respond and to contribute to whatever decisions may be made, he must be considered as beginning to participate, and as exerting some degree of influence, should there be any response on his part to this encouragement at this stage.

Item 4.

As the new member begins to realize more and more that he is being accepted, his opinions sought and his decisions respected, he gains in confidence and begins to feel that he does, in fact, have an influence upon the application of the program. At this stage in his acceptance of the program the member can be considered as having reached the "consultation" level of the guide. Here again the writer does not consider this "consultation" level to be that of "tokenism," as suggested in Arnstein's typology, but that of even greater participation since the member's opinions and decisions are actively sought, respected, discussed, and also acted upon if they are considered by the total group to be in their best interest.

Item 5.

The "placation" level of Arnstein's guide does not apply to the participation aspect of A.A. as this implies that while advice and decision-making is encouraged, the right to judge its legitimacy is retained by the power holders. "Placation" level of action would be inconsistent with the equal right given to each member to be heard. Again, while there may be dominant personalities, there are no "power holders" as such within the setting of A.A. group meetings. The writer's experience has been that many older A.A. member intimidate younger ones. This most often results in a general reluctance to discuss or investigate innovative ideas pertaining to an increasing sense of community responsibility.

Item 6.

The partnership level as applied to the A.A. member implies to the writer a greater level of maturity and leadership. He has now passed beyond the level of consultation and now expects his greater contribution to be considered more closely by the other members. He is now better prepared to accept any disapproval of his opinions or decisions. It is at this stage that the member fully accepts the sharing of planning and decision-making responsibility and he now realizes that he is indeed a full partner. It is now his turn to encourage other newcomers to become more involved and to share in decision-making. In consideration of the limitations of decision-making imposed by A.A. structure, it is at this stage that the limit of citizen involvement in A.A. is reached. Thus, this sharing of decision-making and of responsibility in planning, in accordance with the guide, implies the beginning of citizen power.

Item 7.

Since there is no formal power structure in the A.A. group there can be no delegated power resulting in the non-application of this item. It is the policy of the A.A. Fellowship as a whole, as represented by the General Service Board, that full power not be delegated to each A.A.

group insofar as the right to change the philosophy or general policy is concerned. Although it is professed that there is no formal power exercised by the Fellowship through the General Service Board, this appears to the writer as inconsistent with the expressed policy of A.A. as indicated by the fourth tradition, which limits autonomy to matters which do not affect other groups or A.A. as a whole. It would appear that power is exercised by the Fellowship by way of limiting the autonomy of the group.

Item 8.

Full citizen participation in A.A., according to Arnstein's guide, implies that the members would have the right to change the twelve steps and twelve traditions. While not having this right may well be a positive factor in light of the experience of A.A., it is indicative of less than full citizen control of the program.

In the following discussion of the writer's perception of citizen involvement in terms of Dunham's guide for working toward citizen involvement, it should be pointed out that Dunham was writing in connection with the "planning approach." He presents the planning approach as where a city-wide body, which initially may have little representation from target areas, develops a program that will involve residents of those areas (Dunham, 1970, p. 329). In this part of the present discussion the "target area" will be considered as the City of Edmonton. The "city wide body" or "planning body" will be considered as the A.A. members of the city. The discussion will, therefore, focus upon the public relations policy of A.A.

Item 1.

In this "planning approach" it is assumed that the city-wide planning group which "develops a program" should take the initiative in encouraging representation from the target area.

It would be contrary to the basic philosophy of A.A., and particularly to the concept of anonymity, for A.A. to encourage representatives from the general community of Edmonton who may not be alcoholics and who would then share in A.A. decisions. Through twelfth step work, on the other hand, residents of Edmonton who could be considered as representatives of the "alcoholic community" are encouraged to join A.A. However, when we consider the total population of Edmonton in terms of this first item, citizen involvement is not only not applicable but also inoperative in the light of A.A. philosophy and program.

Item 2.

The history of A.A. suggests that it was established more in spite of than because of the expressed inability of science and the professions to help the alcoholic. From an historical point of view, therefore, and from present practical experience, it has been found by A.A. that alcoholics are in the best position to advise other alcoholics, and other citizens, in terms of their own program. This view, which is shared by the writer, explains the lack of advisory bodies to A.A. Also, as in the case of item number one, the philosophy and anonymity of A.A. does not allow for broader citizen involvement by way of advisory bodies.

Item 3.

The A.A. "open meeting" to some extent fills the role of dialogue with concerned citizens but not to the extent of there being involvement by non-alocholic members in A.A. decisions.

Item 4.

The citizens of Edmonton are not generally informed of A.A. program content and suggestions for methods of applying the A.A. program are not solicited. There is, therefore no two-way, and very often not a one-way, flow of information so that citizen involvement is not present.

Item 5.

A.A. does not make efforts to train community leaders, as such, in presenting or organizing alcoholism related programs, but each alcoholic recovered through A.A. is considered as a sort of anonymous "good will ambassador." The fact is that a recovered alcoholic is not anonymous at all. A.A. does not directly involve non-alcoholic citizens in spreading the "message" so that there is no "citizen involvement" in terms of this item.

Item 6.

The only type of volunteer recruitment which is part of the A.A. program is by way of twelfth step work done by A.A. members on a one-to-one basis. Here again there is no citizen involvement.

Item 7.

The suggestion of utilizing non-professional aides as contact persons is, in effect, to the extent that third parties are sometimes involved in the encouragement of alcoholics to join A.A. While there would be citizen involvement to a limited extent in this case, it is not a general policy of A.A.

Item 8.

Some A.A. conferences are open to the general public but with the restriction that those who attend respect the anonymity of alcoholics present. While this is certainly acceptable in itself, these conferences provide only a one-way flow of information from the individual speakers, or panels, and does not provide for the full participation by the general public.

Item 9.

Of all the suggestions of Dunham's guide this is the only one which is followed by A.A. Services on a neighborhood basis is one of the highlights of A.A. methods. This item, however, has no impact upon citizen involvement as the services provided are A.A. meetings. Information services are provided to a limited extent.

While there are elements of community development inherent in the program of A.A. in Edmonton, the limitations of both "citizen involvement" and "community" does not warrant the application of the term to this program.

An A.A. group meeting is a group method of meaningful, as opposed to token, citizen participation, but this participation does not extend to "deciding policy objectives, program goals and methods" as mentioned in the introduction to this chapter. Also, participation is limited to those who belong to A.A. and is not open to all of the citizens of Edmonton who are not members.

The writer considers the A.A. group meeting to be an educational and motivational process consistent with our definition of community development, but this process only adheres to the concept of community self-determination of, and community responsibility for, the actualization of community objectives when the "community" is the A.A.

group and when the "objectives" are those of A.A.

A.A., not being directly concerned with self-determination for all of the citizens of Edmonton in regard to alcoholism education, prevention or rehabilitation, can not be considered as a community development program. In the words of Biddle and Biddle:

> Though the process starts with a few people and continues through the actions of small groups, it is holistic. That is, it seeks a local wholeness that includes all people, all factions (Biddle and Biddle, 1966, p. 74).

In view particularly of the "community" limitations of A.A., this program does not fall within the scope of the community development principles chosen for this study.

The Henwood Rehabilitation Centre

For the purpose of this study the program of the Centre is being considered as having both treatment and training objectives. This section will, therefore, investigate the perceived effect, or impact, of the role of citizen involvement separately with respect to rehabilitation treatment and teaching and training.

The Rehabilitation treatment objective

Citizens' views

The counselling staff recognize that the treatment objectives of the Centre have been established after much research and consultation with authorities in the field of alcoholism. As a result, the staff do not express any difficulty in accepting these as valid treatment objectives. However, since it is the responsibility of the counselling staff to implement the program, it is understandable that there is not always agreement on the methods used in attaining these objectives. They feel that each counsellor has a right to share in the responsibility of adjusting the methods of attaining program objectives which follow from new knowledge about alcohol and alcoholism, as well as from the refinement of counselling techniques.

The counsellors point out that patients present themselves for treatment at different stages of emotional development and, therefore, with different emotional needs. While it is not possible to have a separate program for each individual patient, they maintain that the program should be flexible enough to accommodate individual differences insofar as possible. While the counselling staff have no part in the decision as to who is, or who is not, admitted to the program, they realize that much importance is attached to the criterion of the patient's motivation in wanting to stop drinking. It was noted that this could result in some alcoholism treatment facilities tending to blame the patient when treatment fails. They feel that each failure is not only a challenge for each counsellor to develop more effective techniques, but it is also a reminder of the professional responsibility of continued appraisal of program methods and general policy. A means then for the counsellors to express their concerns in regard to the treatment program and to share in the treatment responsibility which they feel toward each patient is the utilization of the "team approach."

The counselling staff expressed satisfaction that the team meetings, as part of the team approach, provide for democratic representation through their team leader. They feel that this method provides for meaningful and individual impact upon decision-making regarding program methods and their implementation. They consider this impact as being limited by the failure of the other team to come to the same conclusion, or to disagree, in regard to suggested action. Another recognized limitation is that there is no guarantee that even the combined suggestions of both teams will result in the desired action unless the suggestions are agreed to by the general staff meeting comprised of the director, the treatment director, the nurses and the two team leaders. The general feeling seemed to be that these limitations, or controls, are necessary as they allow for the input of administrative opinion formed in the context of greater professional knowledge, managerial experience, or even political necessity.

Policies and procedures also come under discussion at the team meetings. Suggestions in regard to changes in this area are brought to the staff meetings for approval where they are considered in the light of the overall treatment orientation of the program. The policy of application for admission being screened by the director without counsellor consultation appeared to be generally accepted, mainly because it is considered to be a more efficient method, particularly in view of the number of applications.

The administrative staff have expressed satisfaction with the team approach, not only because it has proven to be an efficient method of personnel management but also because it has produced useful contributions for an up-to-date program. While the administration encourages suggestions from counsellors there is no arrangement by which the patients may have a significant voice in general policy or program methods. It is considered that patients who have come for treatment are no more capable of prescribing their own treatment than they have power to be capable of managing their own lives before admission.

In the view of the patients, their involvement in program extends only to their co-operation with it. They have come for treatment because they have known, or been told about, others who have benefited or have recovered through this program. They know that if they do not like what is being done they are completely free to leave. The patients accept the fact that the emphasis of the treatment program is not for them to contribute to program or policy decisions, but rather to enable them to make a lasting and personal decision in regard to recovery from alcohol.

The patient advisory council, comprised of all patients, has its weekly meeting with an elected chairman and officers. The main purpose of this meeting, according to the patients, is the assignment on a rotating basis of housekeeping chores such as kitchen, laundry and library duties. Arrangements are also made at these meetings for hosting a weekly A.A. meeting and for an occasional reunion meeting. Should a patient, or a group of patients, have a reasonable complaint about the general program schedule, program methods or counselling personnel, then an attempt is made to settle the matter without further recourse. Failing this, the matter is brought by the chairman of the council to the Director or the Assistant Director for his consideration. The Director or Assistant Director may then, in turn, bring the concern to the general staff meeting for discussion and solution.

The writer's views

Now the perception of citizen involvement in the rehabilitative treatment part of the Centre will be assessed in terms of Arnstein's guide. The citizen involvement dimension in this part of the program is confined, by the personal nature of treatment, to the participation of staff and patients. Within this context the utilization of Dunham's guide in addition to that of Arnstein would prove to be redundant. Arnstein's guide is chosen, in addition, because Dunham's "planning approach" appears to have greater application to a program with a broader context.

Item 1.

While the levels of "manipulation" and "therapy," as in items one and two, do not apply to the participatory role of the staff in the "team approach" these levels are applicable to the patients.

In the first place, the writer considers all alcoholics who present themselves for treatment [illegible] have been forced, or at least manipulated, to that point by the circumstances of their particular situation. Once the circumstances of their situation has brought them to treatment they have no other choice but to leave if they will not attempt to accept the program. The patients then, are forced to participate in the program if they wish to remain. Many alcoholics have allowed their lives to be controlled by the negative influence of alcohol for many years. It may be the first and the biggest step in an alcoholic's recovery for him to allow the positive influence of such a program to exert a measure of control. Whether this situation is praiseworthy or not is not the question, but in the mind of the writer it does not constitute a form of citizen involvement. This particular citizen, at this stage, generally has such a low opinion of himself and is so self-centered that he is not concerned with becoming involved with other citizens beyond the minimum required for his own sobriety.

Item 2.

By involving patients in group therapy in this program there is no pretension that it is a form of, or a means of fostering, citizen involvement. It is made very clear that this therapy is for the sake of the patient alone and not for the sake of sharing in any decision except that of abstention from alcohol in his own case. While there are varying degrees of participation by the patients in groups, this participation is considered, in terms of Arnstein's guide, as non-participation and therefore as not being citizen involvement.

Item 3.

For new staff members their initial participation in the meetings of the "team approach" is at the "informing" level of Arnstein's guide. During this orientation period information and practical experience is gained in regard to counselling techniques and the "team approach" where, for the new staff member, it becomes a one-way flow of information. While this level of participation is considered as a degree of "tokenism," according to the guide, the writer feels that since this is a necessary part of staff training which looks to, and encourages, greater participation, it is not "tokenism" although not yet citizen involvement.

The patient who has apparently accepted the program and attends group therapy and counselling sessions, lectures and film presentations, is now participating in the program. The effect of this participation upon the patient is not the writer's concern so much as is the fact that the patient now appears to be fully participating to the degree expected and sought by the program. Here again the writer does not feel that the term "tokenism" applies as it would imply that the patient was being given the impression that he had a voice in program decisions. This is the highest level reached by the patient in this program in terms of citizen involvement according to the guide. The writer concludes that, insofar as the patient is concerned, there is no citizen involvement in the treatment aspect of the program.

In the meetings of the Patient Advisory Council the decision-making power which is given to the patients is concerned only with housekeeping duties and does not extend to program policy, goals or methods. Even these minor decisions, as well as any other suggestions which these meetings might produce, are all subject to the approval of the administrative staff. The Patient Advisory Council, while perhaps serving a useful purpose as a sounding board or buffer, is not citizen involvement according to the guide, as it has no voice in decisions regarding program. This non-involvement in program decisions seems highlighted by the fact that staff members attend only upon invitation.

Item 4.

The administration places great emphasis upon the value of counsellors' views to the total treatment program. Before any changes in policy or program, which may affect the total treatment program, are implemented they are presented to the counselling staff by the team leaders for discussion. While there is no guarantee that these counsellor views will always be acted upon, it still reflects more than "tokenism." It is at this "consultation" level that some degree of citizen involvement and influence upon the decision-making process begins. This opinion is not at variance with the guide which indicates this "consultation" level as one of "tokenism" since there could be an element of tokenism involved.

While there is a Patient Advisory Council it is not considered to be at this level, since the council is not consulted on matters of policy or program.

Item 5.

While there is more than token consultation with the counselling staff, it is the writer's opinion that there is no clear cut distinction in this case between "consultation" and "placation." The counselling staff is indeed consulted through their team leader representatives, but these representatives are appointed by the administrative staff and not elected by those they represent. Arnstein's "placation" level is typified by the placing of hand-picked members on boards or committees who are allowed to advise while this advice is subject to the approval of the power-holders.

Not only does the "team approach" of the Centre provide the administration with advice and suggestions for their approval, but it also serves to placate staff who might otherwise feel that they were being manipulated. In this sense then, the consultation and team leader aspects of the "team approach" concept is a degree of "tokenism." Both the "consultation" and the "placation" level in this case are considered as consisting of degrees of participation but not as citizen involvement.

Item 6.

While the planning and decision-making responsibilities for the treatment program are made jointly at the general staff meetings, the counselling staff have no assurance that their contribution will be acted upon. This means that the counselling staff are not at the partnership level of citizen involvement. The partnership level is reached only by the director, the assistant director, the nurses and the two appointed team leaders.

Item 7.

Although the Centre is a facility of the Commission, the power to administer the treatment program is officially delegated to the director of the Centre. The director, through a partnership arrangement, as in item six, shares this power with the administrative staff. The level of "delegated power" as in Arnstein's guide is not reached by this arrangement as this "partnership" is still accountable to the Commission.

Item 8.

There is no "citizen control" in the rehabilitative treatment aspect of the Centre in terms of the guide. This is so because the decision-making power is in the control of a very few of the citizens who are in a position to exercise this control over the majority.

The Teaching and Training Objective

Citizens' Views

In the ten-month period from September, 1972 to July, 1973, there were a total of 501 participants in this seminar from 54 different Alberta communities, as well as from 29 out-of-province locations.

Because of the problems involved in contacting participants in many locations in the limited time available, the writer did not attempt to obtain a sample view of participants in regard to their perception of citizen involvement in this aspect of the program.

It is the perception of the staff that this seminar, as a resource, has an impact upon the later citizen involvement of participants in their home communities, though very difficult to measure. Some staff members consider the seminar as a community development program insofar as it contributes to the development of communities. They concede that there is only a limited degree of citizen involvement in the seminar itself insofar as allowing participants to decide methods or goals for the program. They point out that the seminar is set up to inform and to train in regard to knowledge and methods which are professionally approved and decided upon.

The Writer's Views

The writer first considers his perception of the impact of citizen involvement in the teaching and training aspect of the Centre in terms of Arnstein's guide.

Item 1.

Some 206 of the seminar participants during the time period covered by the vocational breakdown of participants as on page 53 of this study are indicated as being employed by government departments or agencies. This represents over forty per cent of the total number of participants during that time. Although it may not in all cases be a government employment requirement to attend one of these seminars, it is the writer's opinion that it is, in most cases, an expectation of the employer. This is considered as particularly true where the department or agency fills a social or helping role. If we include the 142 nurses and other hospital employees of the already noted breakdown, since the writer feels the same expectation applies, then we have over 69 per cent of seminar participants who have been coerced, expected, or at least encouraged to attend.

Most participants attend this seminar through a degree of manipulation in some form. This is not to say that this precludes citizen involvement in the seminar or that this manipulation is not warranted or beneficial. The writer maintains though that this factor does not encourage citizen involvement to the extent that there might otherwise be.

The central focus of the teaching and training objective of the Centre program is to educate participants rather than to enable them to participate in the planning of the program itself. While there are other aspects to the seminar, its predominantly educational role places it on the level of "manipulation" as in the guide. This one-way flow of information indicates non-participation.

Item 2.

It seems to be assumed that each participant is in need of developing a constructive attitude toward the alcoholic and his problems. It seems that if each participant attended the seminar of his own volition it would be indicative of a "constructive attitude." As Arnstein notes in her "therapy" level, each participant is assumed to be in need of a change of attitude or "cure." One of the methods used to help the participant develop this "constructive" attitude is by scheduling him to attend four regular group therapy sessions with the patients of the Centre. This assumption places the degree of citizen involvement at the level of "therapy" as in the guide, since there is no prior attempt to assess the participants' attitudes.

In regard to the group therapy sessions themselves, they no doubt fulfil the treatment role for the patient but they do not fulfil a citizen involvement role. It appears to be, and may well be intended to be, closer to group manipulation than to democratic group action. Nelson *et al*. note that, "In far too many instances, community development is used to disguise techniques for manipulation" (Nelson, *et al*., 1960, p. 415). To call participation in these group therapy sessions "citizen involvement" would be to disguise "techniques for manipulation" as community development.

Item 3.

While questions and comments are solicited during and after lectures and after film presentations, there is no prior consultation or joint decision-making as to the content or method of presentation. The discussions are directed around a pre-determined theme which does not offer the opportunity for participants to contribute to the content. The seminar in this respect fulfils its teaching role and the "informing" role as in the guide and is a form of tokenism and not citizen involvement. The writer had the impression that the stimulation of discussion and the solicitation of comments is encouraged not so much for the benefit of the staff as for the participants. In this sense also there is only a one-way flow of information and token participation which does not constitute citizen involvement.

Item 4.

The consultation level is reached, in the view of the writer, when the seminar participants are asked to share their experiences with a counsellor and other participants in connection with clinical cases of alcoholism. Each one is also asked to share his views as to useful methods of dealing with the cases. While the greater experience, and perhaps knowledge, of the counsellor is conceded in this area, this level of "consultation" as in the guide is considered to be a degree of tokenism. This is considered so because the right to judge the validity or appropriateness of the methods or solutions is retained by the counsellor. This may well be an effective teaching method but it is not citizen involvement in terms of the guide.

Item 5.

The placation level of the guide implies that hand-picked citizens are placed on boards or committees whose advice is sought but not always followed. This practice is not followed at these seminars. However, in the sense that each participant is asked upon leaving the seminar to submit suggestions for improvement to the program, participation could be considered in a limited way to have reached this level. It is the writer's opinion that, although the participants do not reach this "placation" level in a particular seminar, this level of citizen involvement is reached in view of the possible influence of their advice on the direction of future seminar programming.

Items 6, 7 and 8.

In order for the "partnership" level to be reached, there would have to be the sharing of decision-making responsibilities through joint policy boards, etc. The "delegated power" level would have to indicate that the citizens, and in this case the participants, would have the balance of power assuring accountability of the program to them. For the level of "citizen control" to be in effect the participants would have to be in full charge of all policy and managerial aspects of the program. Prior discussion in this section substantiates the claim that participation in these seminars does not extend to the level or degree of "citizen power" as typified by the last three items of the guide. Participation in these seminars does not constitute citizen involvement in terms of the guide.

The writer's perception of the impact of citizen involvement in teaching and training will be considered in terms of Dunham's guide. In this discussion the "target area" will be considered as the City of Edmonton. The "city wide body" or "planning body" will be considered as the administrative staff of the Centre.

Item 1.

As noted on page 53 of this study, 208 of the 501 participants were from the City of Edmonton. This is a substantial representation of residents from the target area. However, as noted on page 29 of this study, this representation is to be on "directive boards or committees with real decision-making power." Since there are no such boards or committees formed there is no citizen involvement in this seminar in terms of this item.

Item 2.

There are no advisory bodies chosen from the City of Edmonton so that there is no citizen involvement in terms of "target area advisory bodies."

Item 3.

There are no neighborhood meetings or any means of general dialogue whereby concerned Edmonton citizens could contribute to the planning of the seminar. This indicates the absence of citizen involvement in terms of Dunham's guide.

Item 4.

While citizens are not informed of program developments, suggestions are solicited from seminar participants at the end of the five-day period. There is, however, no two-way flow of information within a particular seminar in regard to suggestions for change. This does not meet the criterion of this item for citizen involvement.

Item 5.

One of the objectives of the seminar is to enable the participants to assume a community leadership role upon return to his own community. There is no leadership training, as such, within the seminar, although the information provided could serve as an aid to leadership. Because of a lack of information on seminar "graduates," the citizen involvement criterion of this item is considered as not being met.

Item 6.

All who attend this seminar are considered by the seminar staff to be volunteer participants. While there is no formal volunteer recruitment program, many of those who attend do so after encouragement from former participants. While not recruited, many participants come from volunteer groups or helping agencies. This citizen involvement criterion is met according to Dunham's guide.

Item 7.

Some A.A. members are considered by the staff to be valuable resource persons as to course content and methods used in the seminar. Contact with A.A. members is maintained both through their informal visits to the Centre and on the occasion of A.A. meetings. The use of A.A. members as non-professional aides is an indication of citizen involvement according to Dunham's guide.

Item 8.

It would seem at first glance that there is citizen involvement according to this item since there is target area representation in the seminar, as noted in item one. However, since item one did not meet the criterion of the guide this item does not apply.

Item 9.

The seminar is only available at the Centre and not on the basis of a neighborhood service in any other area or local community. There is then, no citizen involvement according to this item.

In the rehabilitative treatment part of the Centre there is citizen involvement to the "placation" level of Arnstein's guide insofar as the counselling staff is concerned. This indicates that there is not citizen involvement in terms of this study as the counselling staff have no assurance that their suggestions or decisions in regard to policy objectives, or program goals and methods, will be acted upon. The administrative staff is considered as participating to the "partnership" level as in Arnstein's guide. Since the method of decision-making by the administrative staff is not a total group method of participation, there is no citizen involvement as understood by this study. The patients in this aspect of the program do not participate beyond the "informing" level of Arnstein's guide which also indicates a lack of citizen involvement.

In the teaching and training part of the program of the Centre participation is considered as not extending beyond the "placation" level as in Arnstein's guide, and this with reservations. In terms of Arnstein's guide, therefore, and within the understanding of this study, there is not citizen involvement in any aspect of the Centre's program. While there are elements of citizen involvement apparent in the application of Dunham's guide to the teaching and training part of the program, the degree of involvement is not considered to be sufficient to warrant the application of the term "citizen involvement."

The Edmonton Out-Patient Clinic

Citizens' Views

We are concerned here with the effect or impact of citizen involvement as perceived by the staff and clients who participate both in the treatment and informational aspects of the program. While seven of the fourteen counsellors were interviewed, it was not possible to obtain the views of a representative cross-section of clients so that informant bias is considered as a major limitation in this case.

The staff interviewed noted that while the treatment objectives of the Clinic are virtually identical to those of the Centre, the methods of attaining these objectives are, of necessity, different. They pointed out that the residential aspect of the Centre rendered it more conducive to a more structured program with a somewhat "captive" audience. This, in their view, enables the more effective utilization of a "team approach" which offers a greater means of general staff participation in decisions in regard to treatment methods. The Clinic, they indicated, is involved with a more transient type of patient who may not return after one or two counselling sessions. The overall caseload averages out to about 400 per month as against a maximum of 65 at the Centre. These factors, in the view of the counselling staff interviewed, mitigates against the practicality of a "team approach" insofar as particular treatment methods are concerned. The daily variation and number of cases, in their view, necessitates individual counsellor decisions in regard to the methods of attaining the treatment objectives for each case. The counsellors interviewed felt that this method of decision-making in regard to treatment enables each counsellor to tailor the counselling, or therapeutic approach, to the individual patient's needs. The above views were shared by the counselling supervisor.

At the Clinic an attempt is made by the receptionist to balance the number of patients on each counsellor's caseload. It is up to the counsellor and the patient to decide upon the frequency of appointments.

All of the counsellors interviewed stated that there was no citizen involvement in terms of a group decision-making process regarding specific treatment methods or their implementation. They felt that such a process would not only be impossible in view of the type and number of patients but also impractical in the light of the varying needs of patients.

Some counsellors expressed concern with present policy which, in their view, does not allow for greater involvement of Clinic staff in an educational and preventive role in regard to alcohol and drugs. The opinion was expressed that the staff of the Clinic should be expanded to the point of enabling counsellors to go out of the Clinic to various areas of the city actively organizing information programs on alcoholism and drug abuse. Other counsellors supported this suggestion and added that a result of such efforts could be that more citizens would become actively involved in a more expanded resocialization program within the Clinic.

All of the counsellors agreed that a possible reason for greater efforts not being made for more staff involvement within various segments of the community, and for more citizens not becoming involved within the Clinic itself, was the negative connotation and lack of understanding of alcoholism among the general public. Associated with this was the opinion that most people are not yet prepared to cope with the degree of emotional involvement required in any widespread alcoholism educational, preventive or treatment program.

It was generally felt that the knowledge of budget and staff limitations hampered the initiative of some who felt the need for expanded and innovative approaches. While the opinions of the counselling staff are apparently solicited and considered by the administrative staff in the area of general policy and procedures, the writer was left with the impression that the counselling staff themselves have little or no part in change or innovation in this area.

Several patients were interviewed in regard to their perception of citizen involvement in the Clinic. It was the perception of four of the six patients interviewed that participation consisted of acceptance of counselling and attendance at the information series. Two of the six who had progressed further in terms of the program felt that there was more than a one-way flow of information, not only in the discussion groups but in the patient therapy and communications group. They were of the opinion that the opportunity was present for group decisions in regard to developing group support for an abstinence-oriented way of life.

The writer's views

The writer will first discuss his perception of citizen involvement in the Clinic in terms of Arnstein's guide and then in terms of Dunham's guide.

Item 1.

While administrative decisions in regard to hiring and assignment of staff is not citizen participation, these decisions do not fall within the levels of "manipulation" and "therapy" as in items one and two of the guide. This is so because there is no attempt to imply that group decision-making is involved.

As in the case of alcoholics who join for treatment at the Centre, all who enter treatment at the Clinic have been manipulated by others or by circumstances. Some degree of this form of manipulation is carried on through counselling and the various discussion and therapy groups. In the initial stages of treatment through counselling there is not "manipulation" in the sense of the guide since there is no attempt to imply that the patient is involved in any form of group decision-making. There is not citizen involvement in the initial stages of treatment.

Item 2.

While a treatment therapy group may be compared to Arnstein's "therapy" level of participation it cannot be equated with it. Arnstein notes, as in Chapter II of this study, that at this "therapy" level the real objective is to subject the citizens to group therapy in order to "cure" them of some pathology which they are assumed to have. She notes that this "therapy" is performed under the masquerade of involving the citizens in the planning process. In the Clinic the real objective is to subject the patients to group therapy in order to cure them of the pathology which they do have. This is not performed under the masquerade of involving the patients in the program planning process.

As the patient at the Clinic becomes more involved in group therapy sessions he does become involved, in a supportive way, with the collective decision to abstain. Each individual in the group who is attempting to strengthen his own decision to abstain lends support to every other individual in the group with the same aim. This does not constitute a group method of decision-making, but rather a method of lending support to each individual in his own decision to abstain. Insofar as these therapy sessions do not involve the citizen, or patient, in the program planning for the group as a whole, they fall within the level of "therapy" which is non-participation.

Item 3.

The new counselling staff member is informed of policies and procedures as well as the methods of implementing program objectives. The counsellor is expected to be versatile in his approach to counselling techniques or methods he will utilize in a particular case is up to the counsellor, subject to the approval of the counselling supervisor. While the new counsellor falls within the "informing" level of the guide in regard to program decisions, it is not entirely a one-way flow of information as each new counsellor is considered as having something new to contribute by way of information or experience. However, this new information or experience does not necessarily contribute to a new program, or to new policy, but becomes a specific method of operation for that counsellor.

Once counselling sessions for the patient have begun, it ideally becomes a two-way exchange. This involves the patient revealing his problems, his emotions and his opinions, which are subject to interpretation by the counsellor. There is no two-way flow of information insofar as counselling techniques or program methods are concerned. All patients are encouraged and expected to attend the information series. His participation is passive for the most part although he may ask questions and receive answers. The initial wives groups are primarily to inform the wives of patients about alcohol and about ways of coping with an alcoholic husband. The relaxation therapy groups are an information giving group and so primarily are the couples groups and the family counselling groups. The counselling sessions then, the information groups and all other groups, are primarily at the informing level of the guide where there is mainly a one-way flow of information and where participation is not citizen involvement but a degree of tokenism. Item 4.

There is prior consultation by the counselling supervisor with a specific counsellor in decisions pertaining to counselling or group assignments. Since this method of consultation involves only two people, one of whom has the right to judge the legitimacy of the decisions of the other, it is not citizen involvement but a degree of tokenism. While opinions and ideas from the total staff are encouraged, there is no group method by which the counselling staff is assured that their opinions or ideas will be taken into account. This "consultation" is considered by the writer to be the highest level of participation reached by the counselling staff and is not citizen involvement but a degree of tokenism according to the guide.

There is no provision for consultation with patients as to policy, procedure or program.

Item 5.

This level of participation is not reached by the staff or clients of the Clinic as there are no citizen boards or committees which are allowed to advise or plan.

Item 6.

There are no joint policy boards or planning committees with which the administration shares planning and decision-making responsibilities. There is, therefore, no citizen involvement to the degree of citizen power as in the guide.

Item 7.

The balance of power is held by the Commission under the auspices of which the Clinic is operated. This power is delegated by the Commission to the administration of the Clinic but not beyond this level to the counselling staff. Therefore, there is no degree of citizen power according to this item.

Item 8.

Arnstein indicates that when citizens are in full charge of policy and managerial aspects of the program there is "citizen control." Since the counselling staff and/or clients have little or no voice in either program policy or its managerial aspects there is no citizen control in terms of this guide.

Dunham's guide will now be utilized as a term of reference for the writer's perception of citizen involvement in the Clinic. The "target area" will be considered as the City of Edmonton, while the "city wide body" or "planning body" will be considered as the administrative staff of the Clinic.

Item 1.

Since there are no directive boards or committees chosen from the City of Edmonton or from the staff or participants of the Clinic, there is no target area representation and no citizen involvement in terms of this item.

Item 2.

All decisions in regard to policies, procedures and programs of the Clinic are made at the administrative level and apart from citizen advisory bodies there is no citizen involvement in terms of this item.

Item 3.

There is no first-hand means of public expression and points of view in regard to the program of the Clinic. There are no public meetings, except when counsellors are sometimes asked to speak at churches, or young people's meetings, where dialogue takes place between the target area and the planning body. There is no first-hand contact of this nature where concerned citizens might be able either to become more involved with the Clinic. The criterion of item three is, therefore, not met.

Item 4.

Suggestions are solicited from the counselling staff of the Clinic but not from the target area as a whole. Residents of the City of Edmonton as a whole are not informed of program developments at the Clinic except when this information is specifically asked for or if a citizen is one of the few to whom the monthly report of the Commission is sent. The Clinic does not fulfil the requirements of this item on Dunham's guide.

Item 5.

There is no consolidated effort made to train community leaders. It is expected, however, that those interested in leadership in the area of alcoholism treatment or prevention will avail themselves of the information series on alcohol and drug abuse which is a service offered to the public by the Clinic. There is, therefore, no citizen involvement in terms of this item of the guide.

Item 6.

Volunteers are recruited from family members in the sense that a spouse or children are encouraged to become involved in the specific treatment program for an individual. Members of A.A. are also utilized not only as an aid to a particular patient's recovery but also to assist with certain areas of the treatment program such as the information series. In terms of this item, therefore, the citizen involvement criterion is fulfilled.

Item 7.

This item also is accounted for in the utilization of members of A.A. as contact persons and expeditors of the program. In terms of this item citizen involvement is present.

Item 8.

Service by the Clinic is not rendered on a neighborhood basis but only at one location in the city. Citizen involvement is not present in terms of this item of the guide.

In terms of Arnstein's guide, the highest level of citizen participation in the Clinic is that of "consultation" reached by the counselling staff and which, according to Arnstein, is tokenism and not properly called citizen participation.

In terms of Dunham's guide, the Clinic meets the stated requirements of citizen involvement in only two out of the nine items of the guide. Both of these items involve the utilization of members of A.A. which must be considered as a select group within the total citizen population of Edmonton. The writer considers that while the "letter" of the requirement for "recruitment of volunteers" and for the "utilization of non-professional aides" is met, the "spirit" of the requirement is not. In other words, there is no allowance in the Clinic for the participation of the general public in terms of Dunham's guide nor in the sense of citizen involvement as defined in this study.

The Clinic does not provide for a group method of meaningful citizen participation in deciding policy objectives, program goals and methods as well as their implementation. While the program may be considered as an educational and motivational process in some respect, it does not adhere to the concept of community self-determination of, and community responsibility for the actualization of community objectives. This is so because the objectives of the program are those set down by the administrative staff which are not necessarily those of the "community" as understood in this study. The program of the Clinic, therefore, does not meet the requirements of the definition of community development in this study. This being the case the community development principles chosen in this study are not applied in this case.

The High Level Community Program

The effect, or impact, of the workshop and numerous meetings and discussions held in High Level, as noted in Chapter IV, is the basis for investigating the effect, or impact, of citizen involvement in the High Level Alcoholism Program as perceived by the citizens interviewed.

Citizens' Views

It was obvious to the writer that the R.C.M.P. constable interviewed had some strong reservations in regard to the wisdom of the citizen involvement method of attempting to solve the alcoholism problem of the area. The constable, in his contention that the native-white relationship was good and the native-R.C.M.P. relationship excellent, seemed to indicate some apprehension lest citizen involvement "rock the boat." This became more obvious as he spoke of the lack of outside communication as being positive in that it hindered the development of a type of local native "civil rights movement." This constable considered alcoholism as mainly a native problem. He stated that since the community meetings the impact of citizen involvement in regard to the alcoholism problem did not result in a noticeable reduction of intoxicated natives. While he conceded that he did not attend any of the community meetings in regard to the problem, he implied that rather than risking more power to the native people by way of citizen involvement, a better solution would be to improve the recreational facilities of the general area.

The owner of the local hotel and tavern had attended several of the community meetings and indicated that citizen involvement had already contributed to a greater consideration for, and understanding of, the rights and needs of the native people of the area. He noted that there was more support now for his long standing suggestion for a type of "friendship centre" where native people could be sheltered for the night after having travelled a long distance. This man appeared insecure and somewhat apprehensive as to the implications and possible impact of citizen involvement in regard to his drinking establishment.

The local Indian chief attended several of the community meetings and he felt that he and his people were made even more aware of the dangers and extent of alcoholism in the general area. In fact, he expressed the opinion that one very positive impact of the meetings was the final realization by both the native and white people of the general area was that of alcoholism. The chief felt that the community meetings and subsequent discussions produced a greater understanding by the white population of the Indian point of view and thus a lessening of tension between white and native people. He expressed the hope that this understanding would grow now that it was common knowledge that not only the Indians of the area have problems in regard to alcohol. While the chief expressed appreciation for the two-way flow of information and the opportunity for the native people to express their concerns, he did not indicate that the meetings produced a greater understanding by the Indians of the "white man's" point of view. This led the writer to surmise that while there may have been a two-way flow of information the chief paid little heed to the flow from the other direction.

Another very fruitful result of the meetings, according to the chief, was the fact that they led to positive discussion among the Indian people of the surrounding area as to solutions to their many problems. Some of these discussions, he admitted, centered around ways and means of obtaining more material things from the government. In spite of this, the chief felt that one meaningful and far reaching result of these discussions was the formation of an All-Band Council by the seven Indian bands in the area. This All-Band Council was formed to deal not only with the problem of alcoholism but with other problems as well. A further impact of the citizen involvement generated in the area was, therefore, the initiation of more co-operation among the Indians themselves and the initiative to at least consider dealing with their own problems.

While the chief noted these positive results of the community meetings, his expressed resentment and distrust of the "white man" were indications that the native-white relationship still left much to be desired. He was resentful of the fact that the "white man" had initially brought alcohol to the Indians and implied that the solution to the alcoholism problem of the Indians was, therefore, more of a white than an Indian responsibility. The chief complained that the "white man" wanted Indian attendance and co-operation at the meetings mainly to obtain the support needed for government funding of an alcoholism treatment centre in the town of High Level where it would be of more benefit to the "white man" than to the Indians. He also expressed resentment that the High Level alcoholism program was being considered by some as a program representative of all the citizens of the area while not one Indian was on the committee set up to propose a plan of action.

The meeting of the writer with several of the staff of the local hospital, together with the public health nurse and the director of the local office of the Department of Health and Social Development with his assistant, provided a more general viewpoint of the local impact of citizen involvement.

It was the general impression of those at this meeting that the main impact of the meetings held, and of the many discussions which followed, was that it was becoming more evident to the citizens that they had the main responsibility themselves to work out their own problems. Another expressed result of the meetings and of the workshop was that more citizens, including the Indians, were of the opinion that the Indians must accept more of the responsibility for their own alcoholism problems as well as the responsibility for seeking solutions. Related to this was the opinion expressed at this meeting that the Indians must also accept more of the responsibility for making their concerns known. The group felt that there was now much greater hope for better communication and co-operation between whites and Indians as a result of the meetings held.

It was indicated that a major impact of the meetings was a greater understanding of alcoholism generally, as well as the reasons why it is a major local problem. In the view of those at this particular meeting, the community meetings resulted in a growing conviction that for many citizens their lack of commitment to the area led to lack of community responsibility and a consequent rise in the prevalence of alcoholism. Groups of citizens were being formed to discuss ways and means of making life in that isolated area more meaningful. One of the ways apparently being considered for this purpose is an increase in recreational facilities.

It was further indicated that the growing sense of responsibility resulting from the workshop and meetings so far left the desire for as much citizen control as possible over the alcoholism treatment centre proposed for the town. The conviction was expressed that the citizens themselves should have just as much responsibility for the control and operation of any such facility as they had in making such a facility a reality in the first place.

In the interview with an ex-alcoholic who now operated a successful business in the town, it was indicated that one of the results of the community meetings was to bring some of the latent power struggles in the community out into the open. He felt that this was a very positive result in that it allowed for the opportunity to work out local differences and to lessen the number of opposing factions. This man felt that better communication and co-operation resulted from the meetings.

Another important impact of the community meetings, in this man's opinion, was that the resulting general interest and community concern convinced him that members of A.A. have a much greater responsibility to their community than the greater number of members realize. This man was speaking as an ex-alcoholic who did not consider his anonymity as of greater importance than the contribution he could make as a known former alcoholic. He indicated also that he was one of those who as known former alcoholics were the motivating force behind the involvement of the whole area in the problem of alcoholism.

The last interview was with the ex-alcoholic who is credited by many of the citizens of the High Level community with having taken the first step, if somewhat inadvertently, toward involving the community in the consideration of the alcoholism problem. This man's impression of the impact of the community meetings was that they were a sort of "necessary evil" in order for "the government" to approve some kind of alcoholism treatment centre in the area. He felt that the local members of A.A. carried the educational message in regard to alcoholism just as well as any of the community meetings. His main contention was that if the government only agreed with his original proposal for his form of alcoholism treatment and provided, "without all this fuss," the necessary funds, the community would now have the necessary treatment facilities without the opposition of so many other citizens.

The Writer's views

The writer will first discuss his perception of citizen involvement in the High Level alcoholism treatment program in terms of Arnstein's guide. It is to be noted that at the time of research this program was in the initial stages of development and is, therefore, to be considered more as a proposal for a program than as an accomplished fact.

Item 1.

It was the claim of the Indian chief that the "white man" encouraged the co-operation of the Indians, and their attendance at the meetings, simply to gain their support without giving them a voice in the decision-making. If this was true then the level of "manipulation" as in the guide would apply. However, this claim was disputed by the hospital administrator who was responsible for publicizing the meetings. His claim, which was substantiated by at least eight other citizens, was that every effort had been made to encourage the Indians to elect a representative to the committee set up to present a proposal for action. It was implied by some of the white citizens that outside Indian intervention convinced the Indians to "hold out" on their support in anticipation of greater governmental aid for a program which would be specifically for the Indians. It is the writer's impression that there was lack of understanding and communication in this area and that there was no attempt whatever to manipulate the Indians, or any other citizens, in this manner simply to gain their support. Therefore, it is considered that citizen participation was beyond this level of the guide.

Item 2.

In spite of the suspicion of the Indian chief that the workshop and meetings were being used by some of the citizens to gain more power for themselves, the whole plan, insofar as the "encourager" or community development person was concerned was very straightforward. There appears no valid reason for anyone who was willing to fully participate to suppose that there was a "masquerade" of involving citizens in the planning. The attempt to fully involve both Indians and white citizens appeared sincere so that citizen participation was beyond the "therapy" level of the guide.

Item 3.

All of those interviewed, with the exception of the original ex-alcoholic instigator, felt that the series of meetings and the workshop were not only very valuable sources of alcoholism information but also experiences in communication. There was general agreement that there was an exchange of information between citizens themselves, as well as between the citizens and the "encourager." This two-way flow of information places this exchange of information beyond the "informing" level of the guide and it shows not tokenism but citizen involvement.

Item 4.

There was consultation with the citizens of High Level from the time of the first community meeting with the community development officer in June, 1972. Citizen concerns and ideas were taken into account. Participation went beyond this by the time of the workshop in October, 1972. This workshop was an encouragement to the citizens to come up with their own solutions to the problem of alcoholism. Decisions were made by the citizens themselves in regard to program planning, one of which was to place the right for further action with the High Level Composite Health Board. The citizens were not only assured that their concerns and ideas would be taken into account, they saw that their decisions were being accepted. This goes beyond the "consultation" level of the guide and constitutes citizen involvement.

Item 5.

In April, 1973 a committee of five members was elected by the citizens to formalize a proposal for a specific alcoholism treatment facility at High Level. While this committee was not hand-picked as Arnstein's "placation" level indicates, the legitimacy of the committee's proposal was subject to the approval of the Commission. This proposal, which was presented to the Commission in July of 1973, involved the use of government funds for the establishment of the treatment facility so that it was expected by the citizens that their proposal would be carefully considered, particularly in terms of the quality of the proposed service. It was also expected that the political ramifications of establishing a treatment facility at High Level to serve the surrounding area would be carefully scrutinized in view of the opposition of the Indian people.

The fact that a committee was formed and that it was allowed to present a proposal, but that this proposal was subject to the approval of the Commission, suggests the "placation" level of Arnstein's guide which she indicates as the beginning of influence but as a degree of tokenism. In terms of the guide, citizen involvement was in effect up to this stage of program development, but this involvement did not pass beyond the placation level at the time of research termination.

Items 6, 7 and 8.

Because of time, distance and communication problems, it has not been possible to investigate the impact of citizen involvement in the development of the High Level alcoholism treatment program beyond this proposal stage. Insufficient information, therefore, does not allow for consideration of the last three items of the guide.

Dunham's guide will now be utilized as a term of reference for the perception of citizen involvement in the High Level program. The target area will be considered as the town of High Level and an area within a fifty mile radius of the town. The "city wide body" or the "planning body" will be considered as the Commission.

Item 1.

The October workshop of 1972 had an attendance of 45 citizens, of whom 19 were Indian or Metis, representing not only High Level town but also six surrounding settlements as far as 45 miles away. This indicates citizen involvement in terms of the guide.

Item 2.

The five member committee elected in April, 1973 was accepted by the planning body as an advisory body in regard to planning an alcoholism treatment program for the area. This again indicates citizen involvement in terms of the guide.

Item 3.

Representatives of the planning body attended numerous meetings with citizens of the target area over more than a one-year period and for the express purpose of extensive dialogue. This is another indication of citizen involvement.

Item 4.

At all of the meetings between the planning body and target area, suggestions were solicited by the planning body. Appreciation for the extent of two-way information flow was expressed by the citizens so that this criterion of the guide is fulfilled in terms of citizen involvement.

Item 5.

While there were no efforts to train specific community leaders during the developmental stage of the program, the meetings and the workshop were considered by the planning body as means of developing individual responsibility and group leadership. This does not explicitly meet the requirement of Dunham's guide for the training of community leaders and, therefore, does not constitute citizen involvement.

Item 6.

The whole focus of the High Level program was to encourage those who had already expressed interest to recruit other volunteers with the hope that all of the citizens of the community would be affected, if not directly involved. According to this item, therefore, there was citizen involvement.

Item 7.

Since the ideal was to enlist the aid of all who showed interest in the solving of the community problem of alcoholism, this presupposes the utilization of non-professional aides, and in terms of the guide this is citizen involvement.

Item 8.

While one citizen participated in the Centre's teaching and training seminar, there were no great efforts made to encourage such participation. It was considered that during this development stage it was of more importance to encourage local citizens to participate in the community meetings. In terms of the guide, therefore, there was no citizen involvement in this area.

Item 9.

Beyond the town of High Level there was no serious consideration being given to neighborhood service, or service to the outlying areas. It was expected that those in need of service would come to High Level itself. This does not meet Dunham's criterion for citizen involvement.

It is considered by the writer that citizen involvement was quite evident during the developmental stage of the High Level program. There was citizen participation to the placation level in terms of Arnstein's guide and there was citizen involvement evident in six of the nine items of Dunham's guide. The High Level meetings and workshop were examples of a group method of meaningful, as opposed to token, citizen participation in deciding policy objectives, program goals and methods. While the implementation of those specific decisions were not seen at the termination of the research, there was evidence of the positive effects of this decision-making process. Some of those effects were: a feeling of greater communication between whites and Indians; an increase of communication between Indian Bands, as evidenced by the formation of the All-Band Indian Council; a greater understanding of community problems and a readiness to accept the responsibility for their solution.

The findings of this study support the contention that the High Level program, at least in its developmental stage, is community development as understood by this study. This program was developed according to the six principles of community development chosen for consideration.

CHAPTER VI

CONCLUSIONS

The central concern of this thesis has been to conduct an exploratory investigation of the extent and impact of citizen involvement in four Alberta alcoholism treatment programs.

Concepts and issues which relate to the community problem of alcoholism have been discussed and an analytical framework has been utilized as a focus for the study. General case studies of four programs were presented as well as a brief description of the role of citizen involvement in each program. An examination of the perceived impact of citizen involvement in each case was presented. This examination served as a means not only of indicating that program's strengths and weaknesses in terms of citizen involvement, but also its strengths and weaknesses in terms of community development.

During the process of research and analysis the writer has been aware of the limitations of such an exploratory study. The problems associated with analysis of loosely structured interviews were accentuated by the lack of previous research into the citizen involvement dimension of alcoholism treatment programs. In the attempt to use sensitizing concepts as guides for the analytical framework, it was found that some of the characteristics used to illustrate one item of the guide were sometimes applicable to other items. This lack of delineation resulted in some ambiguity as to the impact of citizen involvement. In the application of the guides, it was recognized that an item was often subject to a different interpretation as it applied to a different situation. While these sensitizing concepts were seen as approximations of the extent and impact of citizen involvement, it has become more clear that the findings could be somewhat an artifact of methodological procedures. In the light of these limitations the interpretations and conclusions presented in this study are the product of personal experience and observation, together with research-based insights, which have been clarified by an analytical framework as a sense of reference.

Implications for Community Development in the Four Programs

Alcoholics Anonymous

We have seen that A.A. is a group method of decision-making and that it is an educational and motivational process based upon the philosophy of self-help. A.A. then, consists of some basic community development characteristics. It's main weakness, in terms of community development however, is that it is not concerned with all of the members of the community. Rather, it is concerned only with the here and now alcoholic who becomes involved voluntarily. A.A. seeks to bring about changes in the lives and motivation of people just as community development does. Some of the values and beliefs associated with community development are also associated with A.A. Community development helps people to develop qualities of self-awareness, emphasizes participation and involvement, bases programs upon felt needs and emphasizes self-help. A.A. has these same values but in all of these the focus of community development is the total community while A.A. focuses on one segment of the population. Both community development and A.A. emphasize the desirability of decisions based upon consensus. While there is a high degree of participation and involvement in A.A., the decision-making power does not extend to deciding policy objectives, which is the goal of community development decision-making. Many of the community development characteristics of A.A. could be a great asset in any attempt to create a more healthy cultural attitude toward alcohol and alcoholism.

Alcoholism has been looked upon as personal misconduct, moral weakness, or sin. This concept is still expressed among certain groups in society, and even when unexpressed it still influences the feelings of many toward the disorder. The history of the rise of A.A. suggests that even the medical and other helping professions can do little to help the alcoholic. There has been, and still exists, some hostility within A.A. to other forms of treatment or rehabilitation, which hostility arose in response to these public and even professional attitudes. These attitudes both from without and from within A.A., along with certain "myths" which have arisen among the public because of these attitudes, have so far interfered with the development of an effective community approach in A.A. to providing help to the alcoholic and his family.

One of these "myths" is that nothing can be done unless the alcoholic wants to stop drinking. This emphasis upon a sudden and absolute break from alcohol as a prerequisite for treatment suggests that the very goal which may be beyond the current capability of the alcoholic must already have been achieved. In other words, he must be halfway well before he will be helped to go the rest of the way. This is a requirement that does not apply in other categories of acute or chronic illness when treatment intervention is essential.

Another of these "myths" is that the alcoholic must "hit bottom," i.e., lose job, home, family or health before he will "want to get well." In fact, the requirement that almost total destruction of every positive aspect of his life must have occurred is a poor basis for any sort of program of treatment or rehabilitation.

Still another "myth" is that it is hopeless to treat alcoholism in any case as the patient may reform for awhile but always slips back. This attitude is born of the stigma of alcoholism and is fostered by unrealistic and unscientific expectations. We do not consider treatment of heart disease as hopeless because the patient has a recurrent attack.

All of these "myths" are related in some degree to the problem of motivating the patient. In fact, they serve as an excuse for not dealing with the problem at all. Even A.A. members subscribe at times to the "myth" that nothing can be done until the alcoholic wants to stop drinking himself. The alcoholic thinks, feels, and acts toward himself in the way that the community things, feels and acts toward him. He rationalizes, makes excuses, and blames others; so does the community. He denies his problems and resists treatment; so does his community. The problem then, is not only in motivating the "alcoholic patient" but in motivating the "community patient." Community development, therefore, as an educational and motivational process, has a role to play in an effective community approach to the community problem of alcoholism.

Like commerical advertising in its early and less sophisticated form, community development has primarily acted on the assumption that its role is to give direction to the "felt needs" of the people. Perhaps the time has come for community development to take a page from the book of "big business" and make the stimulation of motivation itself one of its goals. While this would not be according to the traditional community development approach, it would be recognizing realistically that all the needs of the community cannot always be met through the more traditional approach. In the words of Arthur Dunham, there is a choice

> . . . between expanding one's conception of community development to include 'education and persuasion,' or, perhaps, more logically, recognizing that community development must often be supplemented by the methods of education and promotion. . . (Dunham, 1970, p. 189).

In regard to the alcoholic, this stimulation of motivation would mean seeing the task as not limited to telling the alcoholic who is already motivated to seek treatment where and how to find it. Rather, our main emphasis would be to "create" motivation, not only in the alcoholic, but in the community, by way of developing healthy cultural attitudes toward alcohol through the technique of education. This stimulation of motivation through education would not only lessen the stigma still attached to alcoholism but would also help to develop greater community responsibility for the problem of alcoholism.

The present situation is that the community does not accepts its responsibility for the problem of alcoholism. A.A., as a crisis oriented program, is concerned with the here and now alcoholic and not with accepting a community responsibility for prevention, education or treatment of alcoholism. It is the writer's opinion that A.A. is not concerned with alcoholism, nor with alcoholics in general, but only as particular alcoholics relate to A.A. This would suggest that more interest is expressed in perpetuating A.A. than in helping alcoholics in general.

Many who have tried A.A. and have not successfully "made it" for one reason or another could, in the writer's opinion, have been helped if A.A. did more to help the "failures," such as greater encouragement to try other rehabilitative sources.

In a community development type of approach which stressed the "creation" of motivation, A.A. members would be a most positive asset to neighborhood groups. They would be able to make use of their experience in group decision-making and educational motivation. They could act as "encouragers" to the community development process without breaking their anonymity. The encouragement of input to these groups from A.A. "failures" could also help in assessing and perhaps changing A.A.

The Henwood Rehabilitation Centre

The highest degree of participation in decision-making at the Centre was found to be in the "team approach" to treatment. The decisions arrived at by the counselling staff, however, are not directed toward the total community but only to a small segment of it. Moreover, these decisions are subject to the approval of administrative staff and amount to "suggestions" in reality. The administrative staff, in turn, has a commitment to the Commission to see that professionally accepted standards of treatment are upheld. While there was evidence of participation, there was little room, within these confines, for citizen participation in terms of community development.

It is an assumption of community development that all people have the ability to learn and to grow. In the words of Biddle and Biddle, community development is ". . .a group method for expediting personality growth. . ." (Biddle and Biddle, 1965, p. 79). In an alcoholism treatment facility such as the Centre, it is apparent that all people are not seen as capable of learning and growing at the same rate. Although it would be more in line with community development to have the patients also participate in the "team approach" to their own treatment, it might not serve the best interest of either patients or staff. It is assumed that it is the task of treatment to bring patients from a pathological state to one where they are capable of growth. To allow citizens in a pathological state to assume decision-making power in regard to their own treatment would be to assume that they were not sick at all. It is assumed that some patients are unable even to make a responsible personal decision, at least at the beginning of treatment. It is conceded that patients could become increasingly involved as they progressed in coping with their problems, but the practicality of a community development approach in this aspect of the treatment setting is questionable at best. However, the observations of this study indicate that community development does not play a significant role in the treatment program of this Centre, for either staff or patients.

One important theme that emerges from community development studies is the need for utilization of all available resources in the community. This suggests a much greater use of volunteer groups and advisory bodies to the Centre than is presently the case. Such citizen groups would be a useful liaison between the patient and the community, as well as serve as a means of after-care and follow-up. Community development implies that "personality growth" is to take place within the total community and not in a live-in situation apart from it. It has been the writer's experience that for some lower income types of patients it has been a traumatic experience to attempt to translate the teachings and philosophy gained in this segregated and somewhat "posh" environment to the reality of their real world at the end of the treatment period. It is one of the characteristics of community development that the process continues over a period of time and that it is not a "crash" program. Many alcoholics come to the Centre from tragically non-therapeutic settings. Their personality disorders are the badge of their environment. They bring with them a drinking pattern developed over several years. After twenty-eight days in a therapeutic milieu, they are thrust back again into much the same environmental setting which was probably a primary factor contributing to their problem in the first place.

It is true that referrals to the Centre, in the first place, are accepted only from responsible persons or agencies. It would thus seem that the Centre presupposes that this referral person or agency will continue to be involved in the after-care or follow-up of the case. It has been the writer's experience that many referring agencies assume that the patient has been "cured" and has no need for after-care so that he soon returns to his former frinking behavior. Perhaps in recognition of this, but in any case so as to fulfill the role of after-care, the need for continued treatment through attendance at A.A. is stressed to all patients. Besides reinforcing the substitution of dependency from alcohol to A.A. another problem arises. This is in cases where the referring agency is prepared for after-care, or is at least prepared to follow-up the patients, as is the case when patients are on probation or parole. Since A.A. is anonymous this "scared anonymity" makes it very difficult to monitor the continuance of treatment. The Centre then could benefit by taking a page from the "book" of community development and encourage greater involvement of ordinary citizens as well as organized groups in after-care work.

It is suggested that the utilization of this Centre solely for training citizens in a community development approach to the problem of alcoholism might be of much greater benefit to the total community of Edmonton. In such a case the more in-depth treatment which would be needed could be carried out at local hospitals, the Edmonton Alcoholism Day Clinic and the Edmonton Out-Patient Clinic.

There was a degree of participation in the teaching and training seminars of the Centre but the findings of this study indicate that this was more passive than active participation. These seminars could well be the starting point of the totally new community development approach suggested in the previous paragraph. The working out of a specific plan in this direction could be the subject of further research and study.

The Edmonton Out-Patient Clinic

This study has indicated that the program of the Clinic has the lowest level of citizen participation of all the programs considered. One of the most positive treatment aspects of the Clinic is considered to be its allowance for a "tailor made" program for each individual. This individual treatment, however, does not allow for group decision-making on the part of either patients or counsellors. The confidential nature of one-to-one counselling, which is predominant at the Clinic, is another factor which is not conducive to community development at the treatment level since the decisions made are individual ones for the most part.

Because the Clinic deals with a large cross-section of the community, both as patients and as information seekers, and because of its central location, it presents potential for a community development approach. The Clinic is already well known and established within the community as a credible voice. Instead of waiting for clients to come to them, as is now the case, a community development approach would involve the staff in organizing a charette type community process whereby many of the negative connotations of alcohol and alcoholism could be discussed. This would also allow for citizens to become more comfortable in the discussion of emotional problems which so often contribute to the problem.

Even within it's present organizational structure, some method of greater staff participation in the decision-making process could generate the impetus for the implementation of a community development type of approach. There is a great need for this "credible voice" to become more generally heard and to be more innovative.

The High Level Community Program

In this consideration of the implications for community development in this program, it is of major concern to note that it was in the initial stages of development at the time of research. The fact that there was the specific intention to foster the community development process must also be taken into consideration. This was not the case in the other programs.

This study has indicated that there was a high level of citizen participation which suggested the process of community development in action. It was found that there was an increasing sense of community responsibility and a realization that it was up to the citizens themselves to attempt to solve their own problems. This was indicated by the formation of an All-Band Indian Council and by the proposal presented by the community to the Commission. There were indications of greater co-operation between white and native people. A greater understanding of alcoholism and its related problems was expressed.

The study revealed that at the outset of each meeting the role of the Commission staff was explained as being that of resource persons only. While the citizens were encouraged to express their concerns and to make suggestions, it was pointed out by the Commission staff as each meeting began that, apart from responding to requests for information, whatever decisions were to be arrived at in regard to problems or their solution must be independent of Commission input. As a result of this approach, the structure and direction of each meeting was decided upon by the citizens themselves. The Commission staff, therefore, did not take a directive role in the discussions, but participated only when asked to provide some information considered pertinent by the citizens. The attendance at these community meetings varied from twenty to about fifty citizens from various smaller settlements surrounding High Level. It was estimated that approximately fifteen residents attended all of the meetings. At the beginning of the two-day workshop the format was jointly worked out between the Commission staff and the citizens. On both days the workshop had an attendance of 45 persons.

While it was found that the several meetings and discussion gave rise to some latent leadership, it was also found that they led to the development of different community factions in a power struggle. The investigation revealed that there was a great lack of communication which still existed not only between the native and the white people, but also between various other segments and factors within the community. It appeared from the study that some of the negative aspects of the whole process could have been avoided if there had been a resident community development person active in the area. Much "bickering" and "fault finding" took place between meetings when there was no "encourager" present. The findings indicated that there might have been greater consensus of opinion if a much smaller area had been considered as the "community." As it was, many smaller settlements and Indian Bands from as far as eighty miles away from each other were considered as being able to come to the same conclusions. The proposal for action was found to have been "pushed" much too quickly for the community development process to have involved the majority of the citizens of the community.

There was evidence, therefore, of process at work, but also of program being pushed. Each of the several factions within the community were struggling for the "power" that they felt would accompany recognition for "getting the job done." This once again stresses that with a resident community development person there could have been greater assurance of the continuity of the community development process which was evident at the meetings.

The Alberta Alcoholism and Drug Abuse Commission

In view of the fact that three of the four programs investigated were under the auspices of the Commission, some consideration at this point must be given to the community development implications for the Commission itself.

It was only in the High Level community program that a deliberate attempt has been made by the Commission to encourage a community development approach. This is commendable, but it would be indicative of a lack of appreciation for, or understanding of, the positive results of community development in other places if this should be the only attempt. Should the High Level community program appear to be not as effective in the solution to the alcoholism problem as might have been expected, it should not be concluded that no progress was made.

The least that should be expected of the Commission is the encouragement of as many strong, interested and organized citizen groups as possible in seeking solutions to what it well knows is a problem it is unable to cope with alone. It is suggested that members of the Commission, along with many of the staff that are hired, feel that they are really the representatives of the people in the alcoholism field. With this impression they may not be able to understand the formation on a voluntary basis of citizen's groups who could also claim to represent community interests. This would appear to them as an unnecessary duplication. It is, therefore, suggested that the very nature of a governmental Commission may give rise to a lack of understanding of the role of government versus the role of voluntary citizen's groups.

The Need for Further Research

In concluding this thesis it is necessary to restate that an attempt has been made to present conclusions which may serve to stimulate discussion and as a starting point for more intensive research into the application of community development principles and practices to the community problem of alcoholism.

Since this has been an exploratory study, it is required that more research be undertaken to provide a more comprehensive assessment of citizen involvement in the four programs considered. Further research could focus upon a comparative analysis of the treatment success rate of the programs in relation to the citizen participation dimension. A specific objective of future research could be to use a larger sample of citizens of a community and to focus upon their perception of their role in a community development approach to the alcoholism problem.

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